Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	**1199 OCEAN SPRINGS ROAD , OCEAN SPRINGS, Mississippi, 39564**

(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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), MS #2607107 and CI MS #497417 at the facility from 9/08/25 through 9/11/25. The SA investigated CI MS #2607101 for a resident-on-resident incident and investigated CI MS #497417 for misappropriation of funds. There were no citations related to the complaint investigations. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M0500, M0610, M0815, and M1570.	M0000		10/08/2025
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 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	M0500	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident #109 was notified by the Social Services Director of her right to have toileting assistance provided in the manner of her wishes. Resident #48 was born in South Korea and on 09/18/2025 the Social Services Director contacted the Korean Consulate for assistance on obtaining a Resident Identification Card. The Residents Bill of Rights was reviewed and a copy provided to Resident #26 in writing on 09/12/225 by the Admissions Coordinator. The personal private Hospice information was removed from Resident #85's door on 09/11/2025. Education with the Hospice Nurse that placed the signage on the door was conducted on 09/11/2025. 2) Residents that need toileting assistance, that want to obtain personal identification or community access, and all residents have the potential to be affected. 3) Education was provided by the Unit Manager with Licensed Nurses and Certified Nursing Assistants (CNA) that the Residents have a right to have their dignity maintained in choosing how they toilet. Residents that prefer to use a bed pan will have that right honored. Residents will be evaluated for toileting assistance on admit and interviewed as to their preferences. Residents that can tolerate use of a bed pan and prefer to use a bed pan will be provided a bed pan. (F557)	10/08/2025

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

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M0500	Continued from page 1 record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use	M0500	Continued from page 1 Education was provided by the Regional Director of Clinical Services with all staff that Residents have a right to have their request to obtain a personal state identification card or community access honored. Social Services will assist Residents in their request to obtain a personal identification when requested to include transportation. (F561) Education was provided by the Ombudsman with all staff that Resident have a Resident Bill of Rights reviewed with them and a copy provided in writing. Residents Bill of Rights will be provided of all Residents and/or Resident Representative upon admit by the Admissions Coordinator or Social Services. (F572) Education was provided by the Executive Director and Director of Nursing with all staff and Hospice Staff that Residents have the right to personal privacy and not have personal private information posted. Resident' personal and private information will not be posted in a manner that will void Resident Rights to privacy. Any signage with Residents Personal or health information will not be posted on Residents door, walls or room. (F583) New employees will be educated in orientation upon hire. 4) Quality Monitoring will be conducted beginning 09/15/2025 to interview 10 cognitive residents who will be provided incontinent care, 2 times a week for 4 weeks then weekly for two months. This monitoring will be conducted by the Director of Nursing, Licenses Nurse or the Unit Manager to ensure incontinent care was provided, any issues with the incontinent care and was their preference of toileting honored. (F557) Quality Monitoring will be conducted beginning 09/15/2025 by the Social Services Director or the Activities Director with a sample of 10 residents 2 times a week for 4 weeks then weekly for 2 months to ensure assistance is provided per Residents request to obtain a personal state identification care or community access. (F561)	

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M0500	Continued from page 2 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 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	M0500	Continued from page 2 Quality Monitoring will be conducted beginning 09/15/2025 with a sample of 10 Residents 2 times a week for 4 weeks then weekly for 2 months by the Social Services Director, Admission Coordinator, or the Director of Nursing to ensure the Residents Bill of Rights are provided to the Resident and/or the Residents Representative upon admit. (F572) Quality Monitoring will be conducted beginning 09/15/2025 by the Director of Nursing, Unit Manager or Licensed Nurse to ensure Resident private information is not posted in sight or any signage posted with Residents private information. The monitoring will be a sample of 10 rooms 2 times a week for 4 weeks then weekly for 2 months. (F583) All findings will be reported to the Quality Assurance and Performance Improvement Committee starting 10/01/2025 monthly for 3 months or until substantial compliance is met.	

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M0500	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure a resident's right to dignity and respect when staff required her to wear a brief against her preference instead of providing assistance to the bathroom or a bedpan (Resident #109), to personal privacy by posting identifying hospice information on a resident's door (Resident #85), to provide residents or their resident representatives (RRs) with copies of the Resident Bill of Rights and admission documents at the time of admission (Resident #26) and request for assistance in obtaining personal identification, resulting in a delay of more than one year without follow-up (Resident #48) for four (4) of 22 sampled residents. Findings include: A review of the facility's policy, "Resident Rights" dated 11/30/2014, revealed "… The Facility will not use or disclose the resident's health information without the Resident's authorization…" Resident #109 On 9/9/25 at 11:05 AM, in an interview, Resident #109 reported that the night shift staff told her she would need to wear a brief rather than being assisted to the bathroom or put on a bedpan, despite her reporting that she does not wear briefs. On 09/10/2025 at 4:15 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that Resident #109 was already admitted to the facility when she came on shift and she recalled that she thought the resident was wearing a pull-up at that time, and she suggested that a brief might be easier than a pull-up since it would not require pulling up and down. LPN #1 confirmed that the evening shift staff, including herself, used a bedpan for the resident, and she personally assisted the resident onto the bedpan, which she tolerated well. She stated she did not know why the night shift staff chose not to use the bedpan and	M0500		

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M0500	Continued from page 4 instead placed the resident in a brief. On 09/11/2025 at 11:00 AM, during a follow-up interview with Resident #109 and her daughter, both explained that when the resident was admitted to the facility, she was not wearing a pull-up or a brief. The daughter stated she dressed the resident at the hospital and confirmed she was wearing panties with an incontinence pad for accidents. The resident reported she continues to wear panties and does not want to feel degraded or disrespected by being asked to wear a brief. She emphasized that she never requested either a brief or a pull-up. The resident explained that when staff attempted to place a brief on her, she objected and only stated that if staff insisted, a pull-up would be preferable to a brief. On 09/11/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained that she does not expect any staff to place a brief or pull-up on a resident who is continent, as this is both a resident rights and dignity issue. A record review of the “Admission Record” revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery. A record review of the “BIMS” (Brief Interview for Mental Status) document, with an “Effective Date” of 09/10/2025 revealed Resident #109 was cognitively intact. Resident #85 On 9/8/25 at 10:26 AM, during an observation of Resident #85’s room, signage was posted on the resident’s door sign labeled “(Proper Name of Hospice Provider)” with the resident’s first initial and last name highlighted in yellow stated “Call (Proper Name of Hospice Provider) First.” Resident #85 was lying in bed and was unable to verbalize awareness of hospice services or knowledge of the signage posted on her door. On 9/8/25 at 12:40 PM, during a phone interview with Resident #85’s resident representative (RR), she reported that she had not requested the hospice sign to be placed on her mother’s door. She explained that the sign was placed there by the hospice provider. On 09/10/2025 at 1:20 PM, during an interview and observation with the Hospice Coordinator, she confirmed the sign posted on Resident #85’s door regarding	M0500		

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M0500	Continued from page 5 hospice services and acknowledged she was aware that signage disclosing resident-specific health information should not be posted. She confirmed the sign was clearly visible to anyone passing by the room. She stated she did not authorize the posting of the signage and had not been informed that it had been placed. On 09/10/2025 at 1:50 PM, during an interview with the Director of Nursing, she stated she was not aware that a hospice sign had been posted on Resident #85's door. She explained that staff are trained and aware that resident privacy must be protected and that personal health information should not be displayed. She was unsure whether hospice staff or another individual placed the sign. She stated it is her expectation that staff notify her immediately if any signage containing resident-specific health information is posted, and that such signage be removed right away. On 09/11/2025 at 2:40 PM, during an interview with the Administrator, he confirmed he had been informed that Hospice had placed a sign on a resident's door. He explained there should never be any posting of signage containing resident-specific health information, as this violates a resident's right to privacy and dignity. A record review of the "Admission Record" revealed the facility admitted Resident #85 on 10/16/24 with current diagnoses including Dementia. A record review of Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/25 revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident's cognition was severely impaired. A review of Section O revealed she was receiving hospice care. A record review of the "Order Summary Report" revealed Resident #85 had a Physician's Order, dated 1/30/25, to admit the resident to hospice services. Resident #26: A review of the facility's "Admission Agreement" revised 5/25, revealed that Section #20 (items a–o) requires residents or their representatives to sign acknowledging receipt of copies received including the Resident Bill of Rights, Resident Handbook, and other admissions documents. On 9/8/202 at 2:00 PM, during a resident council meeting, Resident #26 stated she did not recall receiving various admissions information during the	M0500		

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M0500	Continued from page 6 admission process. She stated she was admitted to the facility on 8/30/25. On 9/10/25, at 4:45 PM, an interview with the Admissions Coordinator, who has been employed in the position since January 2025, revealed that she has not provided residents or their representatives with a copy of the Resident Bill of Rights or the resident handbook during the admission process. She stated that since the facility's recent acquisition, staff have not been able to order resident handbooks and that resident rights documents were not available to distribute. She acknowledged that although residents and representatives signed the admission agreement acknowledging receipt of the items, she had no materials available to provide. On 9/11/25, at 12:23 PM, during a follow up interview, Resident #26 stated she admitted herself and did not recall receiving a folder with signed admission documents unless her daughter may have taken it. On 9/11/25, at 12:46 PM, the Resident #26's emergency contact and relative stated that no admission paperwork was sent home with her following Resident #26's admission. On 9/11/25, at 2:58 PM, the Admissions Director stated she had completed Resident #26's admission paperwork face-to-face on a Saturday. She recalled verbally explaining the documents but admitted she did not provide physical copies to the resident because she did not have access to a copier in the field. She confirmed that Resident #26 did not receive any admission documents during the admission process. Record Review of the "Admission Record" revealed the facility admitted Resident #26 on 8/30/2025 with diagnoses including Surgical Aftercare following Surgery on the Nervous System. Record review of Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/6/2025, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognitive functioning. Resident #48 On 9/8/25 at 12:31 PM, in an interview, Resident #48 stated she had requested assistance from the facility in completing paperwork and obtaining a state identification (ID) card but that her request had not	M0500		

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M0500	Continued from page 7 been fulfilled. On 9/10/25, at 8:34 AM, during an interview, the Social Services Director stated she had no knowledge of Resident #48's request for assistance with obtaining an ID. She reported the resident frequently brought her Humana insurance mail but had not made the ID request directly to her, acknowledging that the resident may have told the Social Services Assistant instead. On 9/10/25 at 10:50 AM, during an interview, Social Services Assistant (SSA) #1 recalled Resident #48 previously requested transportation to the Department of Motor Vehicles (DMV) to renew her license and obtain a state ID. SSA #1 stated the resident's out of state driver's license and state ID were expired, and the resident was informed that a birth certificate was required. SSA #1 reported the request had not been resolved due to turnover in the social services department and lack of follow-up from the prior social worker. She confirmed the resident had been transported to multiple DMV locations but was unsuccessful each time because she did not have a birth certificate. SSA #1 explained that the resident would need to apply for a birth certificate through another country's embassy before the ID could be obtained. On 9/10/25 at 4:45 PM, during a follow up interview, the Social Services Director confirmed that the Social Services Assistant had knowledge of the process to obtain a birth certificate and acknowledged that the matter had not been resolved for Resident #48. On 9/11/25 at 5:25 PM, during an interview with the Administrator, he revealed his expectations for the Social Services Department are to ensure resident requests are honored. A record review of the "Admission Record" revealed the facility initially admitted Resident #48 on 8/21/2014 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/8/25, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These	M0610	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Resident #91 was shaved by Certified Nursing Assistant (CNA) #1 on 09/09/2025 and Resident #109 was provided incontinent care by CNA #1 on 09/09/2025.	10/08/2025

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M0610	Continued from page 8 shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for residents who are dependent upon staff, related to incontinent care (Resident #109) and shaving (Resident #91) for two (2) of 22 sampled residents. Findings include: A review of the facility's policy, "Activities of Daily Living (ADLS)" dated 02/01/2022, revealed "… To encourage resident choice and participation in activities of daily living (ADL) and provide…assistance as necessary … ADLs includes bathing, dressing, grooming, hygiene, toileting … Procedure…2. CNA (Certified Nurse Aide) will provide needed … assistance to resident…" Resident #109 A record review of the "Admission Record" revealed the facility admitted Resident #109 on 9/8/25 with diagnoses including Aftercare Following Joint Replacement Surgery. On 9/9/25 at 11:05 AM, during an interview, Resident #109 reported she had been left in a soiled brief since 6:00 AM. She stated she pushed the call light several times, but staff turned the light off without returning to provide care. The resident's daughter, present at the time, confirmed she arrived at 9:00 AM, remained until 10:10 AM, returned at 10:30 AM, and no staff had checked on or changed the resident during that time. On 9/9/25 at 11:30 AM, during an interview, Certified Nursing Assistant (CNA) #1 reported she had not checked on or changed Resident #109 during her shift and stated she had been told in report that the resident went to	M0610	Continued from page 8 2) Residents that require staff assistance with Activities of Daily Living (ADL) care have the potential to be affected. 3) Education was provided by the Unit Manager and the Director of Nursing with all Licensed Nurses and CNAs on providing ADL care to include incontinence care and shaving for Residents that need assistance. Staff will provide encouragement to Residents for ADL care and incontinent care when indicated. All new hires will be educated in orientation upon hire. 4) Quality Monitoring by Resident interview and observation will be conducted with a sample of 10 Residents 2 times a week for 4 weeks and then weekly for 2 months by observation and interview beginning 09/15/2025 by the Director of Nursing, Unit Manager or License Nurse to ensure Residents are receiving ADL care to include incontinent care and shaving as needed. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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M0610	Continued from page 9 the bathroom independently. She acknowledged she was not familiar with the resident. On 9/9/25 at 11:45 AM, during an observation, CNA #1 checked Resident #109 and confirmed her brief was saturated, and the bed was soiled, requiring a complete bed change. On 9/9/25 at 11:50 AM, during an interview, the facility Ombudsman stated the facility had received numerous complaints from residents being left in soiled briefs for long periods of time. On 09/11/2025 at 2:00 PM, during an interview with the Director of Nurses (DON), she explained all staff are to be aware of residents' needs to provide the appropriate quality of care for each resident and that a resident left in a soiled brief for hours is not acceptable. Resident #91 A record review of the "Admission Record" revealed the facility admitted Resident #91 on 11/16/22 with diagnoses including Paraplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #91 was dependent on staff for personal hygiene, toileting, and bathing. On 9/8/25 at 11:11 AM, during an observation, Resident #91 was lying in bed watching television. Thick facial hair was noted on the resident's chin and neck. The resident stated she liked to have her facial hair shaved but staff often forgot to do so. On 9/9/25 at 4:15 PM, during an observation, Resident #91 remained with long facial hair. She stated she disliked having facial hair, but that staff forgot to shave her. On 9/9/25 at 4:30 PM, during an interview, CNA #2 explained Resident #91 was a day-shift shower/bath resident and female residents were supposed to be shaved on shower days. She stated whether Resident #91 was shaved was dependent upon the CNA assigned and acknowledged the resident currently had long facial hair. CNA #2 stated Resident #91 was always cooperative and did not refuse care.	M0610		

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M0610	Continued from page 10 On 9/10/25 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #2 stated she noticed Resident #91 with long facial hair both the previous day and that morning. She explained that CNAs were instructed and in-serviced to provide shaving during bathing or shower care. She confirmed Resident #91 did not refuse care and was cooperative. On 9/10/25 at 2:10 PM, during an interview, the DON stated residents were to be shaved during ADL care, including women. She stated a female resident with long facial hair on her chin was not acceptable and staff were expected to provide the needed care. On 09/11/2025 at 2:30 PM, during an interview with the Administrator, he confirmed that residents left sitting in urine or not receiving timely care was unacceptable and not consistent with facility practices. He stated he expects all residents who are dependent on staff for ADLs to be treated in a dignified manner. He further explained that if staff observe long facial hair, especially on a female resident, it is their responsibility to provide shaving unless the resident refuses, in which case the refusal must be documented in the record.	M0610		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain food quality and hygienic practices in accordance with professional standards for food safety related to overly ripened produce, improperly stored food, exposed food, expired food, and unsanitary handling of ready-to-eat food for two (2) of (2) kitchen observations. Findings include: A review of the facility's policy, "Sanitation Inspections, Nutrition, and Food Service," with an effective date of 11/30/2014, revealed, "…Each item is labeled and dated before refrigeration… Avoid indiscriminate handling of foods with fingers. The proper use of hands, gloves and serving utensils shall be taught to all food handlers..." On 09/08/2025 at 10:15 AM, during an observation and	M0815	1) Root Cause Analysis was conducted by the Interdisciplinary Team. Outdated food items and overly ripe foods were discarded, pantry flour lid was secured, and teriyaki and soy sauce was discarded on 09/08/2025 by the Dietary Manager. Pantry flour bin lid was secured, and teriyaki and soy sauce was discarded. 2) All Residents had the potential to be affected. 3) Education was provided by the Dietary Manager on Food Storage and Procurement and food handling to maintain food quality and hygienic practices in accordance with professional standards of practice for food safety related to food storage, overly ripe foods, expired foods and unsanitary handling of ready-to-eat food. New hires will be educated in orientation upon hire. 4) Quality Monitoring by observation will be conducted with a sample of 5 observations 2 times a week for 4 weeks then weekly for 2 months beginning 09/15/2025 by the Dietary Manager to ensure food quality and hygienic practices in accordance with professional standards of practice for food safety related to food storage, overly ripe foods, expired foods and unsanitary	10/08/2025

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M0815	Continued from page 11 interview of the kitchen with the Dietary Manager (DM), Refrigerator #1 was observed to contain two (2) small plates with individual portions of lettuce, tomato, and onions that were not dated, and one (1) cut piece of overly ripe cucumber with dark spots. Refrigerator #2 was observed to contain four (4) bunches of overly ripe celery with withered leaves that were soft and flexible, one (1) opened bag of salad mix with a manufacturer's "Best if Used By" date of 9/4/25, and five (5) heads of iceberg lettuce with slimy dark leaves and visible white biological growth. The pantry was observed to have a flour bin with the lid left open, exposing the flour, and opened gallon-sized bottles of teriyaki sauce and soy sauce with manufacturer instructions to refrigerate after opening. The DM acknowledged the overly ripe produce, exposed and expired food, and improper storage. He stated he and the cook were responsible for maintaining food quality and that staff were in-serviced monthly on food safety. On 09/09/2025 at 11:19 AM, during a follow-up observation of the kitchen service line and staff interviews with the Baker, she was observed preparing resident trays while picking up bread rolls and pieces of fried fish with her gloved hands, arranging chicken and potatoes on plates with her gloved hands. The Baker confirmed she was handling food with her gloved hands and acknowledged the importance of using sanitary practices to prevent cross-contamination. She stated staff received food safety in-services every two (2) weeks. During the same observation, a Dietary Aide (DA) was observed removing a serving spoon from a pan of potatoes, using it to push chicken from one plate to another, then using the same spoon to serve carrots. The DA was further observed placing bread rolls and pieces of fried fish on plates with her gloved hands. In an interview at this time, the DA acknowledged she had handled food with her gloved hands and confirmed she knew food should be handled with proper utensils. She stated staff received in-services on food safety every two (2) months. The DM acknowledged the unsanitary handling of food observed during tray service. He stated his expectation was for staff to use utensils for ready-to-eat foods to prevent contamination and foodborne illness. He reported he would conduct additional staff training. On 09/11/2025 at 11:37 AM, during an interview, the Administrator acknowledged he was made aware of the observations of overly ripe produce, exposed food, expired food, and unsanitary food handling practices. He confirmed that it was the responsibility of the DM and Cook to maintain food safety standards and stated	M0815	Continued from page 11 handling of ready-to-eat food. Finding will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	

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M0815	Continued from page 12 he would implement daily monitoring to ensure compliance.	M0815		
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, 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to prevent the possible spread of infection by not implementing contact isolation precautions timely for (Resident #47) and enhanced barrier precautions (EBP) when providing care for (Resident #4) for two (2) of 22 sampled residents. Findings include: A review of the facility's "Policies and Practices - Infection Control," revised October 2018, revealed, "This facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. Policy Interpretation and Implementation…2. The objectives of the infection control policies and procedures are to: a. Prevent, detect, investigate, and control infections in the facility b. Maintain a safe,	M1570	1) Root cause analysis was conducted by the Interdisciplinary Team. Contact Isolation for Resident #47 was placed on the door and Enhanced Barrier Precautions (EBP) signage was placed on Resident #4's door. Education was provided by the Director of Nursing for the Nurse Practitioner, License Practical Nurse #2 and Certified Nursing Assistant #4 on proper requirement of Personal Protective Equipment (PPE) and that Residents with wounds should be on EBP and gowns are required. 2) Residents on Contact Isolation or EBP have the potential to be affected. 3) Education was provided by the Director of Nursing with all staff on EBP with an emphasis on PPE and signage required for EBP and contact isolation. EBP will be used to reduce the spread of Multidrug-Resistant Organisms by using gloves and gowns for Residents with wounds. Signage indicating type of precautions and PPE required will be placed on the outside of the door. Contact Isolation precautions will be implemented when a Resident has a transmissible infection. Signage will be placed on the door to inform the staff of the type of precautions, instructions for use of PPE, and instructions to see nurse before entering the room. New hires will be educated in orientation upon hire. 4) Quality Monitoring will be conducted with a sample of 5 Residents with EBP or Isolation precautions 2 times a week for 4 weeks then weekly for 2 months beginning 09/15/2025 by the Infection Prevention Nurse or the Unit Manage of residents on EBP and Contact Isolation to ensure resident room doors have appropriate signage and to ensure staff are wearing appropriate PPE. Findings will be reported to the Quality Assurance and Performance Improvement Committee monthly starting 10/01/2025 for 3 months or until substantial compliance is met.	10/08/2025

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M1570	Continued from page 13 sanitary, and comfortable environment for personnel, residents, visitors, and the general public c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions…" A review of the facility's policy, "Enhanced Barrier Precautions," dated August 2022, revealed, "…Enhanced barrier precautions (EBPs) are used to prevent the spread of multidrug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation…2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. A. Gloves and gowns are applied prior to performing high-contact resident care activity…" Resident #47 On 9/8/25 at 10:00 AM, during an observation, there was no signage on doors on the 500 Hall indicating residents were on contact isolation precautions. Resident #47, who resides on the 500 Hall, was in her room, lying in bed with his eyes closed. There was no signage on the door indicating contact isolation precautions. On 9/9/25 at 9:08 AM, during an observation, there was signage on Resident #47's door as well as personal protective equipment (PPE) indicating the resident was on contact isolation. Red barrels with biohazard bags were also placed inside the resident's room. On 9/9/25 at 10:15 AM, during an interview, Registered Nurse (RN) #2 stated Resident #47 had tested positive in the hospital for COVID-19 and was admitted to the facility on 9/5/25. RN #2 stated she was not working on 9/5/25 and confirmed the facility failed to follow infection control protocol at the time of admission by not placing the resident on isolation precautions. RN #2 stated she normally ensured the contact isolation signage, PPE, and biohazard barrels were placed in the resident's room, and going forward, the admission nurse would assist in ensuring infection control protocols were followed when she was not working. RN #2 confirmed that failing to follow infection control protocol could cause the spread of infection to other residents and staff. A record review of the "Admission Record" revealed the facility admitted Resident #47 on 9/5/25 with diagnoses	M1570		

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M1570	Continued from page 14 including COVID-19. A record review of the resident's Entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/25 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated she was cognitively intact. A record review of the "Order Summary Report" revealed Resident #47 had a Physician's Order, dated 9/8/25, which was three (3) days after admission, for isolation related to positive Covid test.. Resident #4 On 9/10/25 at 10:51 AM, during an observation of wound care provided by the Nurse Practitioner (NP), Licensed Practical Nurse (LPN) #2, and Certified Nursing Assistant (CNA) #4, the staff washed their hands and wore gloves, but failed to wear gowns. LPN #2 removed the old bandage on the resident's left hip, and the NP removed staples from the incision. There was no enhanced barrier precautions signage on Resident #4's door. On 9/10/25 at 10:59 AM, during an interview, LPN #2 and CNA #4 confirmed they failed to wear gowns while providing wound care. They stated they typically wore gowns when providing wound care and normally looked for signs on the door stating EBP. They confirmed there was not a sign on the door, and they did not think about wearing a gown at that time. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 8/20/25 with diagnoses including Left Femur Fracture. A record review of the Admission MDS, with an ARD of 8/27/25, revealed Resident #4 had a BIMS score of 13, which indicated he was cognitively intact. A record review of the "Order Summary Report" revealed Resident #4 had a Physician's order, dated 8/21/25 for Enhanced Barrier Precautions related to wounds. On 9/10/25 at 11:17 AM, during an interview, the Director of Nursing (DON) stated staff should wear gowns and gloves when removing staples from an incision or providing wound care. The DON stated EBP required the use of gowns and gloves during wound care, and an EBP sign should have been placed on Resident #4's door. The DON also stated a contact isolation sign and PPE should have been placed on Resident #47's door.	M1570		

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M1570	Continued from page 15 On 9/11/25 at 1:10 PM, during an interview, RN #2 stated an EBP sign, and PPE should have been placed on Resident #4's door when the resident was admitted. RN #2 stated the facility failed to place the sign and PPE on the door because she was not working that day. She stated she was unaware that the sign and PPE were missing. RN #2 stated staff could spread infection by not wearing gowns while providing wound care and that it was facility protocol to follow Enhanced Barrier Precautions. On 9/11/25 at 2:20 PM, during an interview, the Administrator stated he expected the facility to follow contact isolation and EBP policies when providing care.	M1570		