STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A402	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST P O BOX 207 BLDG 33, WHITFIELD, Mississippi, 39193

(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 an annual recertification survey at the facility from 10/06/2025 through 10/09/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F658, F684, F698, F809, F812 and F880. The facility had a census of 76 and was licensed for 90 beds.	F0000		
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 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	F0656		

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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F0656 SS = D	Continued from page 1 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 record review, staff interview, and facility policy review the facility failed to implement the resident's care plan for monitoring dialysis weights and identify changes in condition for one (1) of (32) sampled residents (Resident #9). Findings include: A record review of the facility policy "Care Plan Policy," no date, revealed, "…2.Policy: A comprehensive, person-centered care plan will be developed and implemented for each resident by the interdisciplinary team, (IDT), resident, and his/her legal representative to include measurable objective and timetables to meet the resident's physical, psychosocial, and functional needs…" A record review of the "Care Plan Report' with a date initiated of 7/30/2025 revealed "Focus: ARF (At risk for) Altered nutritional status r/t (related to) CKD/ESRD (chronic kidney disease/End Stage Renal Disease) …Interventions/Taks…Notify MD (Medical Doctor)/RD (Registered Dietician)/Correspondent of any significant weight changes..." However, there was no individualized care plan intervention to address the resident's ongoing need for dialysis, nor was there direction to monitor pre- and post-dialysis weights, communicate with the dialysis clinic, or evaluate trends in fluid balance—despite the resident's End Stage Renal Disease diagnosis.	F0656		

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F0656 SS = D	Continued from page 2 On 10/09/2025 at 2:27 PM, in an interview with Registered Nurse (RN) #1 who serves as the Care Plan Nurse, revealed the importance of the care plan is to set a baseline of care for residents clearly written so that any nurse could see, follow and know exactly what that resident needs are. RN #1 further stated the significance of having dialysis weights for care plan is to inform staff of significant changes in resident before and after dialysis. A record review of the “Identification and Summary Sheet” revealed Resident #9 was admitted to the facility on July 23, 2025, with diagnoses that included End-Stage Renal Disease (ESRD).	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review the facility failed to ensure completion and follow-up of resident communication forms used to coordinate care services, resulting in potential unmet resident needs in one (1) of (1) sampled resident receiving dialysis. Resident #9. Findings include: Record review of the facility policy “Hemodialysis Care” effective September 2024 revealed, "…When a patient/resident is determined by a physician/nurse practitioner to need hemodialysis, the dialysis treatments will be provided by a contracted entity. The outside medical facility will arrange, develop, implement, and exchange information with Mississippi State Hospital (MSH) regarding the patient's/resident's specific dialysis care plan…" A record review of the “Identification and Summary Sheet” revealed Resident #9 was admitted to the facility on July 23, 2025, with diagnoses that included End-Stage Renal Disease (ESRD), requiring routine dialysis. Record review of the Minimum Data Set (MDS) with an	F0658		

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F0658 SS = D	Continued from page 3 Assessment Reference Date (ARD0 of July 30, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A record review of the “Dialysis Communication Form” revealed missing documentation of pre- and post-dialysis weights for August 6, 8, 11, and 18, 2025. On October 8, 2025, at 3:33 PM, Registered Nurse (RN) #2 was interviewed and stated that the dialysis nurses are responsible for completing the weights on the communication form. She acknowledged that when the forms were returned incomplete, facility staff assumed there were no issues requiring follow-up and did not request the missing information. On October 8, 2025, at 3:42 PM, the Dialysis Manager at the local dialysis center stated that the dialysis nurses or technicians are responsible for completing the communication form and returning it to the facility. She further stated that if forms are missing or incomplete, it is standard practice for the facility to call the dialysis center and request the missing information via fax or email. The Dialysis Manager had no knowledge of any request made by facility staff to obtain the missing data for Resident #9 for the listed dates. On October 9, 2025, at 8:50 AM, the Director of Nursing (DON), acknowledged that this was the facility's first dialysis resident and referred to the situation as a learning opportunity. She stated that her expectation is for staff to follow professional standards, policy and procedure and to ensure communication of any resident care concerns. The DON further stated she believes staff did not act with intentional neglect, but rather lacked training in monitoring dialysis residents, which contributed to the error.	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684		

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F0684 SS = D	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the provision of physician-ordered care and services for a resident receiving dialysis treatment. Specifically, the facility failed to accurately correspond, obtain, and document dialysis weights for one (1) of 32 sampled residents. (Resident #9). Findings include: A record review of the “Identification and Summary Sheet” revealed Resident #9 was admitted to the facility on July 23, 2025, with diagnoses that included End-Stage Renal Disease (ESRD), requiring routine dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD0 of July 30, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A record review of Resident #9's "Dialysis Communication" forms revealed that no pre- or post-dialysis weights were documented for August 6, 8, 11, and 18, 2025. A record review of the “Physician Orders” dated 9/20/25 revealed dialysis treatments three times per week, a renal-high diet, and orders for vital signs weekly and as needed, and weights monthly and as needed. During an interview on October 8, 2025, at 3:05 PM, Registered Nurse (RN) #3, stated that nursing staff had never completed pre- and post-dialysis weights for residents receiving dialysis. She explained that dialysis-clinic nurses were responsible for documenting residents’ pre- and post-treatment weights within the dialysis unit records and on the dialysis, communication forms, but facility nursing staff were expected to obtain dialysis weights. During an interview on October 8, 2025, at 3:33 PM, Charge Nurse/Registered Nurse (RN) #2, stated that pre- and post-dialysis weights were completed by dialysis-clinic staff. RN #2 explained that when dialysis communication forms were returned without weight information, facility nurses assumed the omission indicated there were no concerns requiring communication. RN #2 acknowledged the incomplete documentation on the dialysis forms and confirmed that staff had not contacted the dialysis clinic to obtain the missing information, assuming “no changes” had	F0684		

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F0684 SS = D	Continued from page 5 occurred. During an interview on October 9, 2025, at 8:50 AM, the Director of Nursing (DON) stated that communication between the facility and the dialysis clinic is maintained through written, verbal, or electronic means. She explained that dialysis information, including weights, graft function, and diet changes—is used by the interdisciplinary team to monitor the resident's progress and referenced to the medical director if significant. She acknowledged that Resident #9 was the facility's first dialysis resident and described the incident as an opportunity for staff learning. The DON stated that staff had not intentionally disregarded standards but lacked training on monitoring dialysis residents and completing related documentation. She stated her expectations for nursing staff are to remain professional, follow policy and procedure, and promptly communicate changes to the physician. On October 9, 2025, at 2:27 PM, Registered Nurse (RN #1), emphasized that dialysis weights are critical indicators for assessing changes in the resident's condition before and after dialysis.	F0684		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to ensure accurate and complete documentation of dialysis weights for a resident receiving hemodialysis. Specifically, dialysis weights were not recorded on the dialysis communication form for four (4) of 30 dialysis treatment days during August 2025. Resident #9. Findings include: A record review of the facility's "Hemodialysis Care" policy, effective September 2024 revealed, "…II. POLICY: When a resident or patient is determined by a physician or nurse practitioner to need hemodialysis …	F0698		

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F0698 SS = D	Continued from page 6 the outside medical facility will … exchange information with Mississippi State Hospital regarding the resident-specific dialysis care plan… III. PROCEDURE: …3. C. The nurse will document in the patient's or resident's medical record any significant psychological or physiological changes of a patient or resident receiving dialysis and report such changes immediately to the provider..." Record review of "Dialysis Communication" forms revealed that no pre- or post-dialysis weights were documented for August 6, 8, 11, and 18, 2025. A record review of the "Identification and Summary Sheet" revealed Resident #9 was admitted to the facility on July 23, 2025, with diagnoses that included End-Stage Renal Disease (ESRD), requiring routine dialysis. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD0 of July 30, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A record review of "Physician Orders" dated 9/20/25 revealed dialysis treatments three times per week, a renal-high diet, and orders for vital signs weekly and as needed, and weights monthly and as needed. On October 8, 2025, at 3:05 PM, during an interview Registered Nurse (RN #3), who stated that nursing staff had never completed pre- and post-dialysis weights for residents receiving dialysis. She explained that dialysis-clinic nurses were responsible for documenting residents' pre- and post-treatment weights within the dialysis unit records and on the dialysis, communication forms, but facility nursing staff were expected to obtain dialysis weights. On October 8, 2025, at 3:33 PM, during an interview Charge Nurse (RN #2), stated that pre- and post-dialysis weights were completed by dialysis-clinic staff. RN #2 explained that when dialysis communication forms were returned without weight information, facility nurses assumed the omission indicated there were no concerns requiring communication. RN #2 acknowledged the incomplete documentation on the dialysis forms and confirmed that staff had not contacted the dialysis clinic to obtain the missing information, assuming "no changes" had occurred. On October 8, 2025, at 3:51 PM, during a phone interview with the local dialysis manager stated that dialysis communication forms are sent with the resident	F0698		

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F0698 SS = D	Continued from page 7 for each treatment and that pre- and post-treatment weights are recorded by the dialysis nurse or technician. The manager stated that if the form is incomplete, facility nurses can contact the dialysis center to have the completed form faxed or emailed. When asked whether the facility contacted the dialysis facility regarding missing documentation for August 6, 8, 11, or 18, 2025, the manager stated she had no knowledge of any such requests. On October 8, 2025, at 3:41 PM, during a phone interview with the dialysis center Social Worker, confirmed that pre- and post-dialysis weights are completed by the dialysis nurse or technician and that if the forms are incomplete, facility staff usually call or fax the dialysis center to obtain the missing information. She stated that in this case, she had not received any requests from the facility for follow-up. On October 9, 2025, at 8:50 AM, the Director of Nursing (DON) stated that communication between the facility and the dialysis clinic is maintained through written, verbal, or electronic means. She explained that dialysis information, including weights, graft function, and diet changes—is used by the interdisciplinary team to monitor the resident's progress and referenced to the medical director if significant. She acknowledged that Resident #9 was the facility's first dialysis resident and described the incident as an opportunity for staff learning. The DON stated that staff had not intentionally disregarded standards but lacked training on monitoring dialysis residents and completing related documentation. She stated her expectations for nursing staff are to remain professional, follow policy and procedure, and promptly communicate changes to the physician. On October 9, 2025, at 2:27 PM, Registered Nurse (RN #1), stated that when weights are not provided on the dialysis communication form, nursing staff should obtain the weights themselves or call the dialysis clinic to request them. She emphasized that dialysis weights are critical indicators for assessing changes in the residents' condition before and after dialysis.	F0698		
F0809 SS = E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the	F0809		

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F0809 SS = E	Continued from page 8 community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received meals at regular intervals not exceeding 14 hours between the evening and morning meal, or 16 hours when a bedtime snack is provided, for residents residing in the facility for one (1) of three (3) days of survey. Findings include: On 10/09/2025 at 10: 05 AM, an observation revealed Residents in building #31 were eating breakfast. On 10/09/2025 at 10:28AM, during an interview the Director of Operations (DO) stated breakfast was serviced at 9:45 AM, two (2) hours later than scheduled times for the residents in building #31. On 10/09/2025 at 11:05 AM, the DO stated that snacks are served at 10 AM and 2 PM daily and given at night for the diabetic residents. Residents who are not diabetic have access to snacks if they ask. She further confirmed that if a non-diabetic resident did not ask for a snack on Wednesday night, they would have gone almost 17 hours without a meal until breakfast Thursday morning (10/9/25). She confirmed that Food Service Aide (FSA) states dinner was served at 5 PM Wednesday night. On 10/09/2025 11:15 AM, in an interview the FSA stated when he arrived at 10:05 AM today the resident was eating breakfast. He confirmed that the dinner was delivered to the building at 4:30 PM and was served to the residents at 4:55 PM on 10/8/25. A record review of “Meal Times and Location” for	F0809		

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F0809 SS = E	Continued from page 9 Jefferson INN building #31 revealed documented dinner time was 5:15 PM and Breakfast time is 7:45 AM. A record review of building #31 "Food Temperature" log dated 10/8/25 revealed arrival time for dinner was at 4:30 PM. On 10/09/2025 at 3:17 PM, in an interview with the Nursing Home Administrator (NHA) confirmed that she is aware of the meals being delivered late. She stated her expectations is the food be served on time, hot, looks and tastes appealing.	F0809		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review the facility failed to ensure that food was prepared and served in a sanitary manner to prevent foodborne illness. Specifically, a food-service worker was observed failing to change gloves after touching a door handle while taking food temperatures. This failure demonstrated a breach of proper hand-hygiene and glove-use procedures and created a risk of cross-contamination for one (1) of four (4) dietary	F0812		

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F0812 SS = E	Continued from page 10 observations. Findings include: A record review of the facility's "Food Storage "policy (revised June 2025) revealed, “Employees will maintain good personal-hygiene practices and safe food-handling procedures during food storage.” A record review of the facility's "Food Preparation and Meal Service" policy (revised June 2025) revealed, “Employees will observe safe-handling practices during preparation and service of food to residents and patients.” An observation on October 9, 2025, at 8:09 AM, during breakfast temperature checks in the dietary department, the State Agency observed Dietary Member #2 (DM #2), who had been employed at the facility for 24 years, open the kitchen door while wearing gloves. DM #2 then returned to taking food temperatures without removing the gloves, washing her hands, or donning new gloves before resuming food handling. On October 9, 2025, at 8:15 AM, during an interview, DM #2 acknowledged that she should have removed her gloves, performed hand hygiene, and applied new gloves after touching the door handle which was a surface that may have been contaminated. DM #2 also stated that proper hand hygiene is important to prevent the spread of germs and to maintain food safety during food preparation and service.	F0812		
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,	F0880		

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F0880 SS = D	Continued from page 11 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 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.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A402	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-JEFFERSON INN	3550 HWY 468 WEST P O BOX 207 BLDG 33, WHITFIELD, Mississippi, 39193

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F0880 SS = D	Continued from page 12 §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 observations, interviews, record reviews and facility policy review, the facility failed to prevent the possible spread of infection during wound care as evidenced by failure to implement proper use of Enhanced Barrier Precautions (EBP) during wound care for one (1) of three (3) care observations. Resident #11 Findings include: A record review of the facility's "Standard Precautions & Enhanced Barrier Precautions" dated 6/2024 revealed “2. POLICY: All employees will utilize Standard Precautions or Enhanced Barrier Precautions when indicated, on all patients/residents at all times...3.… Enhanced Barrier Precautions expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated. High contact resident care includes Wound care (any skin opening requiring a dressing…” A record review of the EBP signage revealed “…Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities...Wound care: any skin opening requires dressing…” On 10/06/2025 at 2:43 PM, during initial tour, Licensed Practical Nurse (LPN) #1 was observed in Resident #11’s room providing bilateral wound care on his legs. LPN#1 did not have a gown on while providing care. On 10/6/25 at 2:50 PM, during an interview LPN #1 confirmed she did not have a gown on doing wound care. She stated she was aware that she was supposed to wear a gown. She stated she did not look at the EBP signage by the door. She stated she forgot to put a gown on. She stated the purpose of the gown is to protect the residents from getting an infection from the outside. She stated her actions put the resident at risk for infection. On 10/8/25 at 10:13 AM, in an interview the Director of Nursing (DON) stated LPN #1 should have put a gown on. She stated there is a signage on the outside of the door alerting staff to use EBP when providing certain care. She stated she expects staff to follow policy and	F0880		

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F0880 SS = D	Continued from page 13 procedures while doing care. She stated the nurses have gowns on their cart. On 10/8/25 at 10:28 AM, in an interview with LPN #2 / Infection Preventionist (IP) nurse stated she expects staff to wear gowns and gloves when doing care. She stated she does in services and rounds in the facility every other month. She stated by LPN #1 not wearing a gown, that increased the risk of the resident getting an infection. She stated LPN#1 could have bacteria on her clothes and spread it to other residents. She stated when a resident has open areas there is a risk of spreading infection to the wound by not wearing a gown doing care. A record review of Resident #11 “Identification and Summary Sheet” revealed an admission date of 6/2/21 with diagnoses that included Peripheral Vascular Disease. A record review of Resident #11’s “Physician Order revealed an order dated 9/15/25 “Clean lower extremities (Legs and feet) with NS (normal saline). Apply Silvadene to lower legs. Apply ABD (abdominal) pad and wrap and kerlix daily and PRN (as needed) if soiled until healed.” A record review of Resident #11’s Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F0880		