STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual Relicensure Survey at the facility from 10/20/25 through 10/23/25. During the survey the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and cited M500, M615, M640, M735, and M1570. The facility held a license for 120 beds at the time of survey, and the facility census was 116.	M 000		
M 500	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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 2	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 3 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 the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review, the facility failed to ensure resident protected health information was secured and not visible to unauthorized persons for one (1) of four (4) residents observed during	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 4 medication administration. Resident #10 Findings Include Review of the facility's policy titled "Risk Management Implementation Policy" effective on 3/22/2016 in the section titled "Compliance and Enforcement states "All managers and supervisors are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination ...Compliance with HIPAA (Health Insurance Portability and Accountability Act (a law for protecting sensitive patient health information) is mandatory ...". An observation on 10/21/25 at 8:50 AM with Licensed Practical Nurse (LPN) #1 completing medication administration revealed the LPN left his computer screen unlocked with Resident #10's health information visible to anyone in the hallway while he walked into the resident's room to administer medications. During an interview with LPN #1 on 10/21/25 at 9:00 AM, he stated, "I shouldn't have left my computer screen open with patient information, it violates resident's privacy." On 10/21/25 at 3:09 PM, during an interview with the Director of Nursing (DON), she confirmed that the nurse should have closed or locked the computer screen to protect the resident's privacy when he walked into the room. Record review of the "Admission Record" revealed that the facility admitted Resident #10 on 7/30/2024 with a medical diagnosis that includes Dementia.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 615	Continued From page 5	M 615		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to properly assess and monitor a resident with pressure ulcers to ensure healing for one (1) of 25 sampled residents. Resident #23. Findings Include: Review of the facility policy titled, "Treatment/Services to Prevent/Heal Pressure Ulcers" dated 03/21 revealed, "....7. The pressure area will be evaluated weekly, and the nurse will document the size, location, odor, drainage, and current treatment ordered..." An observation and interview on 10/20/25 at 3:50 PM revealed Resident #23 lying in his bed. He revealed that he didn't take care of his feet, he had blisters that peeled off and stated, "They are sore as a boil." Record review of Resident #23's "Order Summary Report" revealed an order dated 08/18/25 to paint back of ankles with betadine daily. Record review of Resident #23's Electronic	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 615	Continued From page 6 Medical Record (EMAR) revealed no documentation of weekly wound assessments or measurements. An observation and interview on 10/21/25 at 2:32 PM with Licensed Practical Nurse (LPN) #1, revealed that Resident #23 had sores behind his ankles that they painted with betadine daily. He revealed that Resident #23 did not have these sores when he came into the facility, that they developed while there. LPN #1 revealed that he stayed on his back most of the time while in bed and that he rubbed his heels on the sheets a lot and due to the pressure, he developed blisters. An interview on 10/21/25 at 3:30 PM with Vice President (VP) of Senior Services, revealed that they were supposed to have preventative measures in place to prevent pressure ulcers. She revealed that the preventative measures included frequent position changes, floating heels, heel protectors. She revealed that the nurses completed weekly skin assessments and if skin issues including pressure ulcers were identified, they were supposed to let the Registered Nurse Supervisor know so she could assess the wounds, identify the issue, measure and document. VP of Senior Services revealed that they were treating the wounds with betadine daily. VP of Senior Services confirmed that the RNs (Registered Nurses) were not assessing the skin completely and were not measuring the wounds weekly to ensure they were improving and stated, "I don't know how this got missed." An interview on 10/21/25 at 4:00 PM with the Administrator (ADM), revealed that she assessed Resident #23's wounds to his bilateral ankles today, 10/21/25 and measured them. She also confirmed that the wounds were unstageable	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 615	Continued From page 7 pressure ulcers and had not been assessed or measured properly. The ADM revealed that without weekly measurements completed, there was no way to tell if a wound was improving or getting worse. An interview on 10/22/25 at 8:25 AM with RN #1, revealed that a nurse had called her to Resident #23's room a couple months ago and showed her that there was eschar behind his right and left ankles. RN #1 revealed that she assessed him, reported it to the physician and put the order into the computer to paint both wounds with betadine. She confirmed that he had unstageable pressure ulcers and that she forgot to go back and document the pressure ulcers. RN #1 confirmed that she did not measure the pressure ulcer wounds, and this was a failure on her part and confirmed there was no documentation in the computer of wound measurements. She revealed that without proper assessment and measurements, they could not know if the wound was worsening or getting infected and stated, "I dropped the ball." She also confirmed that weekly wound measurements should have been completed and were not. Record review of Resident #23's "Admission Record" revealed the facility admitted the resident on 12/11/24 with medical diagnoses that included Vitamin D Deficiency and Essential Primary Hypertension.	M 615		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 640	Continued From page 8 accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure resident rooms were free from environmental hazards for two (2) of four (4) residents reviewed for accident hazards. Resident #4 and Resident #22 Findings Include: Review of the facility policy titled "Oxygen Concentrators/Humidifiers," unrevised, revealed: "Portable oxygen cylinders must be secured in the resident's room." Record review of a statement on facility letterhead dated 10/22/25 and signed by the Administrator revealed, " ...our organization does not have a formal policy in place regarding the storage of oxygen tanks ..." Review of the facility policy titled, "Safety Sense: Chemicals and Material Safety Data Sheets" revealed that "No chemicals may be present in a resident's room or out on the nursing unit. This would include disinfectant spray, tub cleaner, or any other household cleaner. Staff should keep all chemicals and cleaners (any toxic or poisonous substance) locked in the cabinets that are provided on the nursing units..." Resident #4 An observation of Resident #4 on 10/20/25 at 2:26 PM and again on 10/21/25 at 9:02 AM revealed she was lying in bed with eyes closed	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 640	Continued From page 9	M 640		

wearing a nasal cannula connected to a small oxygen cylinder lying in the bed beside her. A metal oxygen storage cylinder rack was sitting on the floor beside the headboard, containing six unused oxygen cylinder tanks.

An interview with Licensed Practical Nurse (LPN) #2 on 10/21/25 at 10:38 AM revealed Resident #4 was on hospice care and that the portable oxygen cylinders were brought in by hospice and stored in the resident's room for personal use. She stated the facility always stored oxygen cylinders in hospice residents' rooms to prevent mixing them up and reported she was not aware of any dangers associated with storing the portable tanks in the resident's room.

An interview with Registered Nurse (RN) #1 on 10/21/25 at 10:46 AM confirmed the oxygen cylinders for Resident #4 were not currently in use and should have been stored in the designated oxygen storage room. She further stated that oxygen can fuel a fire and acknowledged that a resident's environment should remain free from hazards.

An interview with the Administrator (ADM) on 10/21/25 at 3:20 PM confirmed oxygen should be stored in the designated storage area and not in resident rooms, as it could "shoot off like a missile" in case of a fire.

Record review of the "Admission Record" revealed the facility admitted Resident #4 on 6/29/23 with a medical diagnosis that included Pneumonitis due to Inhalation of Food and Vomit.

Resident #22
An observation and interview on 10/20/25 at 2:35 PM, revealed Resident #22 sitting in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 640	Continued From page 10	M 640		

wheelchair in the doorway of his bathroom. There was a plastic gallon container of a disinfectant cleaner on the top shelf in his bathroom with approximately 50 ounces of yellow liquid inside. There was also a one-quart bottle of mouthwash with approximately 8 ounces of yellow liquid inside. On the mouthwash bottle, there was strip of 2- inch red tape secured across the front of the bottle with "proper name" of the disinfectant cleaner written in black ink. Resident #22 confirmed that the yellow liquid in both bottles was "proper name" of the disinfectant cleaner" and that he had poured some from the gallon jug into the smaller mouthwash bottle to make it easier to handle. Resident #22 revealed that he had a sitter that came in three days a week and the sitter used the cleaner on Fridays to clean his urinals out to help keep the urine smell out.

An interview on 10/21/25 at 10:50 AM with Certified Nursing Assistant (CNA) Manager revealed that residents were not supposed to have cleaning supplies in their rooms. She confirmed that there was a disinfectant cleaner in Resident #22's bathroom in two separate containers and that there was a lot that could happen if residents were allowed to keep cleaning supplies in their rooms. She admitted that the resident could forget what was in the bottle and drink it by mistake or could spill it on the floor and cause a fall. She stated, "You can't ever say stuff can't happen, it's a hazard and anything could happen."

During an observation and interview on 10/21/25 at 11:00 AM, LPN #1 confirmed that there was an old mouthwash bottle with a yellow liquid labeled as "proper name" of disinfectant cleaner and a gallon bottle of a disinfectant cleaner in Resident #22's bathroom. LPN #1 confirmed that cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 640	Continued From page 11 products were not supposed to be kept in residents' rooms or bathrooms because the resident could mistakenly drink it or other residents could enter his room and get into it He admitted that the mouthwash was the same color as the disinfectant cleaner, which would have made it easy for the resident to mistakenly use it to swish his mouth out or drink it. An interview on 10/21/25 at 2:43 PM with the Director of Nursing (DON), confirmed that Resident #22 was not supposed to have cleaning liquid in his bathroom or anything else that might harm a resident. She revealed that the nursing staff were supposed to be checking the rooms on a weekly basis and removing anything that might harm a resident. She confirmed that it was hazardous to leave a disinfectant cleaner in residents' possession because it could be confused with something else and it was poisonous if a resident tried to drink it. She revealed that chemical substances including cleaning supplies were supposed to be kept locked up and away from resident use. Record review of Resident #22's "Admission Record" revealed the facility admitted the resident on 04/09/25 with medical diagnoses that included Unspecified Dementia and Depression.	M 640		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible,	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 735	Continued From page 12 and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5)	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 735	Continued From page 13 years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure that medical record documentation was accurate and reflected the care and treatment provided for one (1) of twenty-five sampled residents. Resident #6 Findings Include: Review of the facility policy titled "General Medication Policies and Procedures," undated, revealed under, "Pre-charting: "Medication Administration Records and Treatment Records are never initialed or signed by the nurse until after the medication or treatment has been given. The practice of pre-charting medication administration or a treatment is a falsification of a medical record and is unacceptable. The medical record is kept current and reflects care, medication, and treatments as they are performed." Record review of Resident #6's October 2025 "Treatment Administration Record" (TAR) revealed an order dated 12/11/24, "PT (Physical Therapy) recommendation: Please put ankle stabilizer on (L) (left) ankle during the day. Check skin for redness and breakdown in the morning document condition of skin." The order was scheduled for 0800 and initialed as applied on	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 735	Continued From page 14 10/20 and 10/21. An observation of Resident #6 on 10/20/25 at 2:58 PM revealed she was sitting in her recliner in her room and was not wearing a left ankle stabilizer. An observation and interview with Resident #6 on 10/21/25 at 10:23 AM revealed she was sitting in her recliner in her room without the left ankle stabilizer. The resident stated she had not been wearing one and stated, "I'm not sure where it is, but it could be in the dresser." An observation and interview with Certified Nurse Aide (CNA) #2 on 10/21/25 at 10:28 AM revealed she usually cared for Resident #6 but was not aware that the resident was supposed to be wearing an ankle stabilizer. CNA #2 located the ankle stabilizer in the resident's drawer but stated the aides were not responsible for applying it. An interview with Licensed Practical Nurse (LPN) #2 on 10/21/25 at 10:35 AM revealed she believed the ankle stabilizer for Resident #6 had been discontinued. After reviewing Resident #6's physician orders, LPN #2 confirmed the resident still had an active order for the ankle stabilizer. She further explained that the order was initiated when the resident was walking but the resident no longer ambulated and, therefore, she assumed it was no longer needed. LPN #2 stated that anyone could apply the device but confirmed she had signed off on the order as completed even though the stabilizer had not been applied. LPN #2 acknowledged that if a physician order was active, it must be followed and should not be documented as completed if not performed. An interview with the Director of Nursing (DON)	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M 735	Continued From page 15 on 10/21/25 at 2:52 PM confirmed that Resident #6's record should not have been initialed as applied if the treatment was not performed. The DON verified that this constituted an inaccuracy in the resident's medical record. Record review of the "Admission Record" revealed the facility admitted Resident #6 on 3/18/24 with a medical diagnosis of Unspecified Dementia.	M 735		
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.	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 16 This Statute is not met as evidenced by: Based on observations, residents and staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection for five (5) of twenty-five (25) sampled residents. Resident #1, 5, 18, 24, and 25. Findings Include: Review of the typed statement on facility letterhead and dated 10/22/25 revealed "We are writing to acknowledge that our organization currently does not have a formal policy in place regarding the storage of nebulizers and CPAP (Continuous Positive Airway Pressure) machines. While we recognize the importance of safe and accessible storage of these devices-both for patient safety and regulatory compliance...In the absence of a formal policy, we are committed to ensuring that all respiratory equipment is stored in a manner that prioritizes safety, cleanliness ..." Review of the facility policy titled "Enhanced Barrier Precautions" dated 8/24 revealed "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms..." The facility policy also revealed under "Initiation of Enhanced Barrier Precautions" ...b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds, and/or indwelling medical devices including urinary catheters, feeding tubes ... even if the resident is not known to be infected or colonized with a MDRO (Multi Drug Resistant Organism) ..." Review of the facility policy titled "Safety Sense:	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 17 Infection Control," undated, revealed under "Yellow Dot Policy": "When a resident is contagious with an infectious illness that is not easily destroyed by antibiotics and may be spread easily from one resident to another, every effort must be made to prevent the spread of this illness. ... a yellow dot is placed on a resident's room door as a communication tool to alert all staff that the resident is on isolation. ... Whatever goes in the Yellow Dot room stays in the Yellow Dot room. If it must come back out, it must be thoroughly disinfected by manufacturer guidelines before it can be used for another resident." Resident #1 An observation and interview with Resident #1 on 10/20/25 revealed her door was closed with a sign posted that read, "Wear a mask when entering." She was lying in bed and stated she has cancer (lymphoma) and had been receiving chemotherapy. She explained she went to the hospital about a month ago and had Clostridium Difficile (C. diff), returned to the facility on antibiotics, and was told the infection had cleared. However, she reported continued diarrhea, stomach cramps, and nausea. She stated staff had collected a stool specimen and she was awaiting results. Record review of Resident #1's "Stool" test, reported 10/21/25, revealed Clostridium Difficile (C. diff) and Sapo virus were detected. Record review of Resident #1's "Progress Notes" dated 10/21/25 at 11:41 AM revealed, "Resident tested positive for C. diff (Clostridium Difficile) and Sapo virus. MD notified and new order given for Flagyl 500 MG (milligrams) TID (three times daily) X (times) five (5) days."	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 18 An observation outside Resident #1's room on 10/21/25 at 3:02 PM revealed the door was closed with no indication that the resident was on contact isolation. There were no biohazard barrels for personal protective equipment (PPE) or trash inside the room. An interview with the Director of Nursing (DON) on 10/21/25 at 3:10 PM revealed that when a resident is placed on contact precautions, a yellow dot should be placed on the door as an alert for staff. Record review of the "Order Summary Report" for Resident #1 revealed no order for contact isolation. An observation on 10/22/25 at 8:10 AM revealed no sign or yellow dot was posted to signify contact isolation. Inside the room, there were no biohazard barrels for PPE or infectious waste. An observation on 10/22/25 at 8:25 AM revealed the call light was on. Certified Nurse Assistant (CNA) #3 entered the room without donning PPE and later exited carrying a breakfast tray, which was then placed on a rolling dining cart. During interview, CNA #3 stated Resident #1 had C. diff when she was first admitted but was "cleared" and no longer had it. An interview with Registered Nurse (RN) 1 on 10/22/25 at 8:38 AM confirmed that Resident #1 tested positive for C. diff the previous day. She admitted that she had informed all staff of the residents that were on contact isolation but admitted the isolation sign and PPE setup had not been completed. She acknowledged the failure could spread infection to staff and other	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 19 residents. An interview with the Administrator (ADM) on 10/22/25 at 9:52 AM revealed her expectation was that isolation should be initiated immediately upon suspicion or confirmation of infection. She confirmed staff failed to implement timely precautions, placing staff and residents at risk. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/4/25 with medical diagnoses including Waldenstrom Macroglobulinemia, not having achieved remission, and Infectious Gastroenteritis and Colitis, Unspecified. Resident #5 An observation on 10/20/25 at 3:11 PM and again on 10/21/25 at 10:40 AM revealed Resident #5 lying in bed with a nebulizer mask lying on top of a bedside table unbagged and a nasal cannula hanging over the top of the nebulizer machine. An observation and interview with RN #1 on 10/21/25 at 10:44 AM revealed the nebulizer mask and oxygen tubing should be stored in a bag when not in use for infection control purposes to ensure germs were not spread. An interview with the DON on 10/21/25 at 2:52 PM revealed they do not store the oxygen cannula in a bag when not in use. She stated they just usually throw the nasal cannula over the top of the concentrator when the resident was not using it. She stated they were supposed to open the nebulizer mask, rinse it and towel dry and lay it on a paper towel to air dry. An interview with the ADM on 10/21/25 at 3:58	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 20 PM revealed the nebulizer mask and oxygen cannulas should not be placed on the bedside tables for infection control purposes. She explained that she was not a nurse but was taught that as part of her training. Resident #18 An observation on 10/20/25 at 2:42 PM and again on 10/21/25 at 11:50 AM revealed that Resident #18's Continuous Positive Airway Pressure (CPAP) mask was lying on the nightstand beside the bed, attached to the CPAP machine, with no protective covering. An observation and interview on 10/21/25 at 2:35 PM with Licensed Practical Nurse (LPN) #3 confirmed that Resident #18's CPAP mask did not have a protective covering/bag and was just lying out on the nightstand. When questioned what the purpose of the mask being stored inside a plastic bag or some type of covering, she stated, "I have no idea, but I can fix it." Record review of Resident #18's "Admission Record" revealed the facility admitted the resident on 4/30/21 with medical diagnoses that included Epilepsy and Insomnia. Resident #24 An observation on 10/20/25 at 2:10 PM revealed that Resident #24 had a suprapubic catheter intact and it was draining amber urine into the catheter bag. An observation on 10/22/25 at 9:35 AM, revealed LPN #1 performed Resident #24's suprapubic catheter care and failed to utilize Enhanced Barrier Precautions (EBP) by not donning a gown prior to the care provided. An interview on 10/22/25 at 9:45 AM with LPN #1,	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 21	M1570		

revealed that he didn't know anything about EBP and stated, "I've not heard of it." He confirmed that he did not put on a gown prior to catheter care and didn't know he was supposed to. He revealed that he did use personal protective equipment (PPE) when dealing with residents on transmission -based precautions.

An interview on 10/22/25 at 9:50 AM with RN #1, revealed that they used EBP for residents in isolation. She revealed that they did not utilize EBP for wounds, foley and suprapubic catheters, or other indwelling devices.

An interview on 10/22/25 at 10:00 AM with the Director of Nursing (DON), revealed that they were supposed to use EBP for residents with wounds, urostomies, foley and suprapubic catheters, and any other indwelling device. She confirmed that EBP should have been used by LPN #1 during Resident #24's catheter care to protect him and help prevent the spread of germs and possible infection. The DON also revealed that they had in-serviced staff on EBP when it first came out and they should be following their protocol. The DON presented the in-service on "Enhanced Barrier Precautions in Nursing Homes" dated 08/07/24 and confirmed that she could not find the signature pages of the staff members in attendance.

Record review of Resident #24's "Admission Record" revealed the facility admitted the resident on 09/18/24 with medical diagnoses that included Multiple Sclerosis and Bladder Disorders in Diseases Classified Elsewhere.

Resident #25

An observation outside Resident #25's room door on 10/21/25 at 11:30 AM revealed a yellow dot on the door indicating the need for EBP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS45SI	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE'S VLG/SIENA CTR	200 DOMINICAN DRIVE MADISON, MS 39110

(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) COMPLETE DATE
M1570	Continued From page 22 An observation and interview on 10/21/25 at 11:33 AM with LPN #1 during medication administration revealed, he administered medications to Resident #25 via Percutaneous Endoscopic Gastrostomy (Peg) tube without using a gown for EBP. He confirmed that he did not apply a gown to administer Resident #25's medications and stated, "I forgot to wear a protective gown for medication administration." He admitted that the purpose of wearing a gown was to reduce infection risk. An interview with the DON on 10/22/25 at 10:36 AM confirmed that LPN #1 should have worn a gown to administer Resident #25's medications to protect the resident from infection. Record review of Resident #25's "Admission Record" revealed the facility admitted the resident on 8/23/25 with a medical diagnosis that included Heart Failure, Unspecified.	M1570		