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 **12/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	**323 INDUSTRIAL PARK DRIVE , LIBERTY, Mississippi, 39645**

(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 Investigation (CI), MS# 2670327, at the facility from 12/1/2025 through 12/4/2025. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit and cited M0085. The census at the time of the survey was 19.	M0000		
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS# 2670327, at the facility from 12/1/2025 through 12/4/2025. MS #2670327 was investigated regarding Resident Rights, Admission and Transfer, Abuse, and Quality of Care and M500 was cited. 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 requirement and cited M610, M715, M815, and M1570.	M0000		
M0085	50.4 THERAPEUTIC ACTIVITIES THERAPEUTIC ACTIVITIES This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide an ongoing program of individualized activities to meet the physical, mental, and psychosocial needs of residents residing on the Dementia Unit for two (2) of two (2) sampled residents reviewed on the Alzheimer's Unit (Residents #9 and #63), with the potential to affect all nineteen (19) residents on the unit. Findings include:	M0085		

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

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M0085	Continued from page 1 A review of the facility's, "Life Connections Program," revised May 4, 2021, revealed, "Policy...Procedures. Life Connection Programs should be designed as an ongoing resident-centered activities program that incorporates the residents' interests... Life Connections activity may be scheduled seven (7) days a week... Specialized activities will be available for residents with cognitive impairment..." Resident #9 A record review of the "Admission record" revealed the facility admitted Resident #9 on 4/5/23 with diagnoses including Vascular Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/25 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. Resident #63 A record review of the "Admission record" revealed the facility admitted Resident #63 on 4/6/22 with diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 9/18/25 revealed Resident #63 had a BIMS score of 3, which indicated her cognition was severely impaired. On 12/1/25 at 10:20 AM, during an observation of the Alzheimer's Unit dayroom, there were no activities in progress and many of the residents were sitting in the dayroom with the television on. On 12/3/25 at 12:07 PM, during an observation and interviews on the Alzheimer's Unit, the residents, including Residents #9 and #63, were seated in the dining hall eating lunch. No music or other sensory engagement was provided. Certified Nursing Assistant (CNA) #1 stated many residents had requested music during meals and that the unit's CD player had been removed some time ago. CNA #1 reported she had requested a replacement from administration, but none had been provided. Resident #9 stated music brought her peace when she was growing up and she desired it now more than ever. Resident #63 stated the residents needed music because it was soothing. On 12/3/25 at 12:46 PM, during an observation of the unit activity board and interview with Resident #9,	M0085		

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M0085	Continued from page 2 there were two calendars posted, in which one was designated for daytime activities and one for evening activities. Neither calendar listed any times for when the activities would occur. The 12/3/25 “Day” calendar listed “This Day in History,” and the 12/3/25 “Evening” calendar listed “Matching Cards,” both without scheduled times. Resident #9 stated she did not know what “This Day in History” was and reported the only activity provided was watching television. She added that staff do not come to interact with them, nor do they perform the activities listed on the calendar. A record review of the Activity Calendar for December revealed a calendar for “Morning Activities” and “Evening Activities” with one activity listed per date and no specified time the activity was scheduled. On 12/3/25 at 12:48 PM, during an interview with CNA #1, she reported that no one comes to the unit to provide activities and that residents “wake, eat, watch television, and sleep. She explained that the residents need some type of additional engagement, something that stimulates them, and commented that just because they have dementia, that does not mean they would not enjoy activities. On 12/3/25 at 12:51 PM, during an interview with CNA #2, she reported that although an activity calendar is posted, no activities are provided and residents remain in the dayroom watching television. She confirmed that no one from the activities department had come to the unit that day. On 12/3/25 at 1:00 PM, during an interview with Registered Nurse (RN) #1, Dementia Unit Manager, she confirmed that activities were not being provided on the unit. On 12/4/25 at 10:36 AM, during an interview with the Activities Assistant Coordinator, he confirmed he was responsible for Dementia Unit activities and acknowledged that many scheduled activities had not been conducted. He stated he was often assigned to other duties that prevented him from completing activities. On 12/4/25 at approximately 10:41 AM, during an interview with the Director of Nursing (DON), she stated she had identified that activities were not consistently provided on the Dementia Unit and had instructed the Activities Assistant Coordinator to conduct activities daily. On 12/4/25 at 10:57 AM, during an interview with the	M0085		

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M0085	Continued from page 3 Administrator, she reported she was not aware that activities were not being conducted. She stated it was regulatory for residents to have activities “every hour on the hour.” She stated music was important to creating a pleasant environment and residents should have music when desired.	M0085		
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 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	M0500		

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M0500	Continued from page 4 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 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;	M0500		

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M0500	Continued from page 5 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 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: Level II Based on interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from invasion of personal privacy when the Administrator took and shared photographs of the	M0500		

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M0500	Continued from page 6 resident without his consent for one (1) of 19 sampled residents. Resident #10 Findings Include: A review of facility's "Residents Rights and Qualify of Life Policy and Procedure", undated, revealed,"...All residents have the right to a dignified existence, self-determination and communication and access to people and services inside and outside the facility..." A record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/12/25, with diagnoses including Quadriplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. On 12/01/2025 at 2:05 PM, in an interview, Resident #10 stated that the Administrator followed him in her personal vehicle when he left the facility to get a haircut on November 5, 2025. He stated that the Administrator took pictures of him and sent them to his mother without his permission. The resident expressed that this upset him and violated his right to privacy. On 12/03/2025 at 9:59 AM, in a phone interview with Resident #10's mother, she stated she had not heard from her son that day (11/5/25) and had asked a friend at the facility to check on him. She reported that the Administrator called her shortly afterward and stated that the resident had gone to get a haircut. The Administrator then texted her pictures of Resident #10 taken at a red light, stating she was watching him from her car. The mother confirmed she did not ask for pictures and stated she felt it was inappropriate and a violation of his privacy. On 12/03/2025 at 10:36 AM, in an interview with the Administrator, she confirmed that Resident #10 frequently leaves the facility independently in his power chair. She stated that on the day in question, she was aware the resident's mother was concerned after not hearing from him. The Administrator reported she took it upon herself to drive and look for the resident. She admitted she took pictures of him from her car and texted them to his mother. She stated she was not thinking about privacy at the time but acknowledged that it could be viewed as a violation of resident rights.	M0500		

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M0500	Continued from page 7 On 12/04/2025, in an interview with the Director of Nursing (DON), she stated she had heard the resident mention something about photos being taken but was unaware of details. She confirmed that photos should not be taken of residents without their consent and doing so would be an invasion of privacy.	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 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: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care, including oral hygiene was provided for one (1) of one resident who required staff assistance with oral care, Resident #57. Findings include: A review of the facility's "ADL Care of A Resident Policy And Procedure," undated, revealed "…Resident ADL care will be provided to the resident according to the individualized resident needs..." A record review of the "Admission Record" revealed the facility admitted Resident #57 on 2/14/25 with diagnoses including Need for Assistance with Personal Care. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated her cognition was severely impaired.	M0610		

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M0610	Continued from page 8 On 12/1/25 at 2:29 PM, during an observation and interview with Resident #57, the resident was lying in bed and reported she did not receive mouth care daily. She explained that when she requested oral care, staff told her they would return but did not do so. She reported her teeth were previously white and had become stained. An observation of Resident #57's mouth revealed visible discoloration and debris on the teeth. She reported the last time she received oral care was the prior Wednesday or Thursday. On 12/2/25 at 3:30 PM, during an observation of Resident #57 lying in bed, the resident reported she had been in bed most of the day and had not had mouth care that week. On 12/3/25 at 3:23 PM, during an observation and interview with Resident #57 at bedside with her spouse present, the resident reported her teeth had not been brushed that day. An observation revealed visible discoloration and mouth odor. On 12/3/25 at 3:45 PM, during an interview with Certified Nursing Assistant (CNA) #5, the CNA reported she was assigned to Resident #57 that day and had provided a bed bath and brushed the resident's teeth once. She explained Resident #57's teeth should be brushed after every meal. On 12/3/25 at 3:50 PM, during an observation and subsequent interview, CNA #5 confirmed that Resident #57 had visible discoloration and debris on the teeth. She reported she brushed Resident #57's teeth that day but acknowledged she should have provided oral care more than once. On 12/3/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that visible buildup on teeth develops over time and not within a few days. She reported her expectation was that Certified Nursing Assistants provide daily oral care, personal care, and hygiene according to individual resident needs.	M0610		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure	M0715		

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M0715	Continued from page 9 medications and biologicals were securely stored and properly labeled when a controlled substance returned by a resident was left unlabeled on a medication cart and when a wound care cart containing treatment chemicals was unlocked and accessible to residents for two (2) of three (3) medication/treatment carts reviewed. Findings Include: A review of the facility's "Medication Storage Policy and Procedure," undated, revealed, "…Policy: 1. Medications and biologicals will be maintained in a secured location only accessible to designated staff…" On 12/2/25 at 1:33 PM, during an observation of a medication cart with Licensed Practical Nurse (LPN) #1, a loose pill was noted in a clear plastic sleeve labeled "12 PM" but without the resident's name, drug name, strength, dosage, or any identifying information. LPN #1 identified the pill as Oxycodone-Acetaminophen Tablet 5-325 milligrams (mg) that Resident #10 had checked out when leaving the facility on pass and returned that morning. The pill had been placed on the cart without a label and without secure storage. On 12/2/25 at 1:35 PM, during an interview with LPN #1, she reported she placed the medication on the cart after the resident returned it and planned to notify the night nurse during shift report. When asked how other nurses would know what the medication was, she acknowledged they would not and confirmed that the medication could be administered in error or diverted since it was unlabeled and unsecured. She stated she should have asked the Director of Nursing (DON) how to handle the medication upon return. On 12/3/25 at 2:18 PM, during an observation and interview with LPN #2, the wound care cart on the 400 hall was observed. Although the cart appeared locked, with the lock pushed inward, all drawers opened freely. The cart contained wound treatment supplies including triple antibiotic ointment, calamine lotion, MediHoney, and Nystatin powder. LPN #2 confirmed she believed the cart was locked but realized it was fully accessible and acknowledged that residents, including cognitively impaired residents, could access the unsecured chemicals. On 12/4/25 at 9:27 AM, during an interview with the DON, she stated the returned Oxycodone 5 mg tablet for Resident #10 should have been destroyed by two nurses per facility policy and should not have been left on the medication cart. She explained the risks included	M0715		

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M0715	Continued from page 10 medication error or diversion since the pill was unlabeled and unaccounted for. Regarding the wound care cart, the DON stated the cart had been unable to lock since September 2025 and should not have been stored on the hallway. She explained the interim process was for staff to pull treatments from the cart and store supplies in the medication room. The DON confirmed residents could ingest wound chemicals if the cart remained unlocked and acknowledged that wandering residents lived on the unit. The DON provided documentation showing the facility received a quote for a new cart on 9/12/25 and ordered a replacement on 11/18/25. A record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/12/25, with diagnoses including Quadriplegia. A record review of the “Order Summary Report” revealed Resident #10 had a Physician’s Order, dated 10/10/24 for Oxycodone-Acetaminophen Tablet 5-325 milligrams.	M0715		
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: Level II Widespread Based on observation, interview, and facility policy review, the facility failed to ensure food items were stored, dated, and maintained in accordance with professional food safety standards for one (1) of three (3) kitchen observations. Findings include: A review of the facility’s “Food Storage Areas Policy and Procedures,” undated, revealed, “…Dry storage areas will be kept in a condition which protects foods from infestation. Procedure: 1. All items must be stored at least 6 inches off the floor...Care of the Storeroom 1. The staff will maintain care of the storeroom according to the following directions…b. New stock is placed in back of previously delivered items so that older stock will be issued first. C. Refrigerated and frozen foods are dated upon delivery. Foods with expiration dates are used prior to date on the package…” On 12/1/25 at 10:30 AM, during an observation of the kitchen with the Dietary Manager (DM), the dry storage	M0815		

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M0815	Continued from page 11 room contained two (2) dry storage bins holding rice and sugar that were not dated. A twenty-five (25) pound bag of Domino sugar and a twelve (12) pound bag of Ellington coffee were stored directly on the floor. A sugar-free no-bake cheesecake mix and a box of powdered sugar were observed opened and stored in clear Ziploc bags without labels or dates. Nine (9) Del Monte bananas stored in a box were black with dark brown spots; one banana was split open, black, and mushy. In the refrigerator, fifty (50) single-serve Hiland chocolate milk cartons were dated 10/27/25, and twenty (20) cartons were dated 11/20/25. Seventy-six (76) single-serve Daily sour cream packs stored in two brown boxes were dated 3/5/25. On 12/1/25 at 10:55 AM, during an interview with the DM, she acknowledged the expired chocolate milk and sour cream should have been discarded on the expiration date. She explained that serving expired dairy products could result in residents developing gastrointestinal illness. She reported she was responsible for checking behind dietary staff. She confirmed that no food items should be stored on the floor, that all refrigerated items should be labeled and dated, that the bananas should have been discarded, and that dry storage bins were required to be dated. She explained the purpose of dating and labeling food items was to prevent spoiled food from being served to residents. On 12/4/25 at 1:25 PM, during an interview, the Nursing Home Administrator (NHA) explained she expected the Dietary Department to follow facility policy and regulatory requirements to ensure resident safety. The NHA reported she expected dietary staff to rotate stock daily and remove all expired food items from the kitchen.	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	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

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M1570	Continued from page 12 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: Level II Based on observation, interview, record review, and facility policy review, the facility failed to implement appropriate infection prevention and control practices during indwelling catheter care (Resident #6), and failed to follow hand hygiene, glove-use, surface sanitation, and Enhanced Barrier Precautions (EBP) requirements during enteral feeding tube care (Resident #70) for two (2) of three (3) residents reviewed for care. Findings include: A review of the facility's "Hand Hygiene Policy and Procedure," dated 4/11/23, revealed, "…Hand hygiene will be performed by all staff consistent with accepted standards of practice, to reduce the spread of infection and prevent cross contamination…" A review of the facility's "Isolation Policy and Procedure," undated, revealed, "…Enhanced Barrier Precautions (EBP): 1. EBP Precautions are utilized for residents that have wounds and/or indwelling medical devices (Central line Catheter, feeding tube…)…2. PPE (Gloves and gown prior to the high-contact care activity) is to be utilized…during high-contact resident care activities…g. Device care or use (Central line, urinary catheter, feeding tube…)." Resident #6 On 12/2/25 at 1:50 PM, during an observation of catheter care performed by Certified Nursing Assistant (CNA) #3 for Resident #6, CNA #3 washed the soiled catheter tubing, rinsed it, and patted it dry while continuously wearing the same gloves. She then touched the resident's shoulder and thigh to reposition him without removing gloves or performing hand hygiene.	M1570		

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M1570	Continued from page 13 On 12/2/25 at 1:55 PM, during an observation of perineal care provided by CNA #4 for Resident #6, CNA #4 removed a soiled brief after a bowel movement while wearing gloves and then used the bed remote with the same soiled gloves, contaminating environmental surfaces. On 12/2/25 at 1:56 PM, during an interview with CNA #4, she confirmed she should have removed soiled gloves and performed hand hygiene prior to touching environmental surfaces. She acknowledged the risk of spreading infections. On 12/2/25 at 2:01 PM, during an interview with CNA #3, she confirmed she should have removed gloves, performed hand hygiene, and reapplied clean gloves prior to repositioning Resident #6. She acknowledged the potential for the spread of infection from the catheter area. On 12/4/25 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated her expectation was that staff change gloves and perform hand hygiene after each care task. The DON reported that CNA #3 could have spread infection from the catheter area and CNA #4 could have spread infection from fecal matter to surfaces in the resident's room. A record review of the "Admission Record" revealed the facility admitted Resident #6 on 1/13/25 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. A record review of "Orders" tab in the electronic medical record, revealed Resident #6 had a Physician's Order, dated 11/25/25 for catheter care. Resident #70 On 12/3/25 at 2:15 PM, during an observation of Percutaneous Endoscopy Gastrostomy (PEG) tube care performed by Licensed Practical Nurse (LPN) #2 for Resident #70, LPN #2 donned a gown and gloves at the entrance and performed hand hygiene before applying gloves. She then opened the clean supply cart multiple times and used the computer mouse while wearing gloves. She entered the room, placed supplies directly on the bedside table without sanitizing the surface or using a barrier, and pressed buttons on the feeding pump while	M1570		

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M1570	Continued from page 14 wearing gloves. She removed the PEG dressing while still wearing the same gloves. She cleaned only the PEG tubing, not the insertion site. She removed gloves and reapplied clean gloves without performing hand hygiene. She dried the tubing with gauze, then again removed gloves, performed hand hygiene, and reapplied gloves. She removed a syringe from a storage bag and attempted to flush 150 cubic centimeters (cc) of water; when the water did not move, she used the plunger, met resistance, and exited the room to obtain a stethoscope. She removed her gown, gloves, and supplies upon exit. On 12/3/25 at 2:45 PM, during an observation of LPN #2 returning to Resident #70's room, she applied gloves without performing hand hygiene and not donning a gown before flushing the tube. She gathered supplies and exited the room without performing hand hygiene. On 12/3/25 at 3:28 PM, during an interview with LPN #2, she confirmed she did not sanitize the bedside table or place a barrier before placing supplies. She confirmed she touched the cart, computer mouse, and feeding pump with gloved hands. She stated she should have removed gloves and washed her hands before beginning PEG care and before re-gloving. She confirmed she removed the PEG dressing with contaminated gloves. She reported she did not perform hand hygiene frequently enough and stated the purpose of Enhanced Barrier Precautions was to protect residents from organisms present on staff clothing. On 12/3/25 at 4:10 PM, during an interview with the DON, she stated LPN #2 should have washed her hands before and after care and upon room entry. She stated the PEG site must be cleaned correctly to prevent infection. She stated a barrier should have been used before placing supplies on the bedside table. She stated Enhanced Barrier Precautions were expected during PEG tube care to protect residents from infection. She reported that the manner in which LPN #2 performed care presented a cross-contamination risk. A record review of the "Admission Record" revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia. A record review of the "Order Summary Report" revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25	M1570		

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M1570	Continued from page 15 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. A record review of the Enhanced Barrier Precautions signage posted on Resident #70's door revealed staff were to wear gown and gloves for high-contact care activities, including feeding tube care.	M1570		