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 **01/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBOUGH HEALTH AND REHABILITATION CENTER	**340 DESOTO AVE EXTENDED , CLARKSDALE, Mississippi, 38614**

(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 re-certification survey with four (4) complaint investigations (CI) MS #2615742, CI MS #2627146, CI MS #2631259, and CI MS #2673507, at the facility from 01/05/26 through 01/08/26. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA cited M650 and M1570 on recertification. During the survey, the SA identified non-compliance and cited M500 related to resident rights and misappropriation of resident funds for CI MS #2627146; M610 related to Activities of Daily Living for CI MS #2615742; and M615 related to treatment and services to prevent and heal pressure ulcers for CI MS #2615742 and CI MS #2631259. Based on the facility's implementation of corrective actions completed on 10/8/25 prior to survey entrance on 01/05/26, the deficient practice related to M500 was determined to be past non-compliance and the facility was found to be in compliance for CI MS #2627146 as of 10/9/25. The census at the time of the survey was 51, and the census was 60.	M0000		
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;	M0500	"Past Noncompliance - no plan of correction required"	

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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);	M0500		

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M0500	Continued from page 3 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 Past Non-Compliance Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure resident trust fund withdrawals were safeguarded from misappropriation, when resident funds were withdrawn without documentation verifying goods or services were provided, for two (2) of 40 residents with trust fund accounts. (Residents #5 and #49). Findings Included: Record review of the facility policy titled "Abuse, Neglect and Exploitation" revealed, "Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property." Resident # 5 An interview with Resident #5 on 1/6/26 at 9:02 AM, she stated that $700.00 was taken out of her trust fund account in May of 2025. She verified that she signed the “Resident Trust Fund Withdrawal” form but received no goods or services in return. She stated that the	M0500		

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M0500	Continued from page 4 facility did replace the money that had been taken out of her account. She further stated that she receives a quarterly trust fund statement. Record review of the “Resident Trust Fund Withdrawal” form, dated 5/15/25, for Resident #5 indicated that she signed for $700.00 to be withdrawn for “personal use”. The form listed the Receptionist as the “Fund Custodian”. An interview with Activities Director on 1/6/26 at 9:38 AM, she stated that the Business Office Manager (BOM) #1 instructed her that Resident #5 needed to withdraw money from her trust fund for personal use. She stated she completed the “Resident Trust Fund Withdrawal” form, obtained the resident signature and retuned the form to BOM #1. She stated that she is usually the one who takes residents shopping or shops for them, but that she had not done this in May 2025 for Resident #5. She further stated that she was not aware of what the money was spent on. Resident # 49 An interview with Resident # 49 on 1/6/26 at 9:55 AM, he verified money had been taken out of his trust fund account but was unsure how much it was or when it was. He indicated that he did sign the “Resident Trust Fund Withdrawal” form but did not recall receiving any goods or services in return. He also verified that the facility replaced the money that was removed and that he receives a quarterly trust fund statement. Record review of the “Resident Trust Fund Withdrawal” form, dated 7/1/25, for Resident #49 indicated that he signed for $1115.00 to be withdrawn for “other: cash advance”. The form listed the facility Receptionist as the “Fund Custodian” and was witnessed by Transporter #1 and Transporter #2. Further review of “Resident Trust Fund Withdrawal” form, dated 7/23/25, for Resident #49 indicated that he signed for $1700.00 to be withdrawn for “other: cash advance”. The form listed Receptionist as the “Fund Custodian” and was witnessed by Certified Nursing Assistant (CNA) #3 and the Maintenance Man. An interview with the Receptionist on 1/6/26 at 10:04 AM, she stated that the BOM is her supervisor. She stated that the BOM would notify her when the resident	M0500		

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M0500	Continued from page 5 needed to withdraw money from their trust fund and what it was for. She stated she was responsible for filling out the “Resident Trust Fund Withdrawal” form, explaining what the withdrawal was for, and getting the resident signature. She then turns the form into the BOM who withdraws the money. She verified that two (2) witnesses are required if the resident has difficulty signing. She stated that on 7/1/25 and 7/23/25 that BOM #1 told her that Resident #49 was withdrawing the money to “spend down” his account so that he was not over the resource limit for Supplemental Security Income (SSI). She stated that she was unsure what the money was spent on. An interview with CNA #3 on 1/6/26 at 10:33 AM, she verified that she witnessed Resident #49 sign the “Resident Trust Fund Withdrawal” form on 7/23/25. She stated that she was not aware of what the money was spent on. Record review of the initial audit performed by the facility and corporate office on 9/25/25 indicated that $1115.00 was withdrawn from Resident #49’s’ account on 7/1/25 and $1700.00 was withdrawn from his account on 7/23/25 with no receipt and the check made out to [Proper name of the facility]. Further record review of the initial audit performed by the facility and corporate office indicated that $700.00 was withdrawn from Resident #5’s account on 5/15/25 with no receipt and the check made out to [Proper name of the facility]. An interview with BOM #2 on 1/7/26 at 9:00 AM, she stated that she had received a letter from the Social Security Administration on 9/18/25 for a resident indicating that the resident’s income exceeded the resource limit for SSI and it prompted her to initiate an audit of resident trust fund accounts beginning 9/22/25 to 9/24/25. She indicated this audit identified withdrawals from the resident’s trust fund account with no receipts of where the money went. BOM #2 stated that if the resident wishes to withdraw money from their account or needs to “spend down” their account she informs the receptionist who completes the “Resident Trust Fund Withdrawal” form, obtains the resident’s signature, with witnesses if required, and returns the form to her. She then enters the information into the computerized resident fund management service, indicating what the transaction is for and a check is generated. She further explained that the facility has specific persons who are allowed to sign the checks,	M0500		

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M0500	Continued from page 6 and two (2) signers are required. A third employee will take the check to the bank to be cashed, and the money is brought back to the facility and secured until it is given to the resident or sent with the Activity Director for shopping. She stated that receipts are returned to her so she can reconcile what was withdrawn with what was spent. She verified there were no receipts for the 5/15/25 withdrawals from Resident #5's account or the 7/1/25 and 7/23/25 withdrawals from Resident 49's account. An interview with the Administrator (ADM) 1/7/26 at 9:25 AM, he stated that after receiving a letter from the Social Security Administration for a resident indicating that the resident's income exceeded the resource limit for SSI the BOM #2 notified him and the corporate office for a full audit of the resident trust fund accounts. He verified the audit identified unauthorized withdrawals and/or withdrawals lacking supporting documentation from resident trust fund accounts. He stated the facility identified BOM #1 as the alleged perpetrator at the time of the withdrawals. The ADM confirmed affected residents required reimbursement due to missing funds. ADM verified that BOM #1 was terminated from her employment at the facility on 7/31/25. An interview with the ADM on 1/7/26 at 12:00 PM, and a record review of the facility investigation, audits, in-service sign in sheets and trust fund deposit record verified that on 9/22/25 – 9/24/25 an investigation and audit was performed to determine if withdrawal of funds from resident's trust fund accounts were either not authorized by resident or responsible party or lacked supporting documentation for the withdrawal. The facility replaced funds for any residents with discrepancies in their accounts. Responsible parties of each resident identified were notified by nursing staff on 9/24/25. Education was provided on 9/24/25 to the BOM, the Activity Director, and the ADM on the policy and procedures for resident trust in relation to resident shopping and "spend downs" by the regional Business Office Manager. All facility staff received education on Abuse and Neglect with an emphasis being placed on misappropriation of funds/residents rights which began on 9/24/25. Affected residents were reimbursed on 10/8/25. A follow-up interview with the ADM on 1/8/26 at 9:05 AM, confirmed that the incident and investigation results were presented to the Quality Assurance Committee on 9/24/25, during which the facility policy	M0500		

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M0500	Continued from page 7 was reviewed with no revisions made and the facility continued to monitor all transactions monthly. Record review of the “Admission Record” revealed the facility admitted Resident #5 on 5/3/19 with a diagnosis of Acute on Chronic Diastolic (Congestive) Heart Failure. Record review of the “Brief Interview for Mental Status” dated 10/9/25 indicated that Resident # 5 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #49 on 4/28/23 with a diagnosis Systemic Lupus Erythematosus. Record review of the “Brief Interview for Mental Status” dated 10/24/25 indicated that Resident # 49 was cognitively intact. Based on the implementation of the facility's corrective actions on 10/8/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 10/9/25, prior to the State Agency (SA) entrance into the facility on 01/05/26. Validation: The SA validated on 1/8/2026, through interview and record review that all corrective actions had been implemented as of 10/8/25, and the facility was in compliance as of 10/9/25, prior to the SA’s entrance on 1/5/26.	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.	M0610		

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M0610	Continued from page 8 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure residents who required assistance received grooming and personal hygiene, including nail care (Resident #2, 21 and 24) and cleanliness of clothing (Resident #21) for three (3) of 50 residents observed for activities of daily living (ADLs). Findings Include: Review of facility policy titled “Activities of Daily Living (ADLs), with a review date of 11/7/2025, revealed, “…Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care…” Resident #2 During initial rounds on 1/5/2026 at 11:05 AM, Resident #2 was observed lying in bed wearing a hospital gown with approximately one-half of an inch (1/2") in length nails with jagged edges and a thick, brown substance underneath. During an interview and observation on 1/6/2026 at 10:35 AM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that the Certified Nursing Assistants (CNA)s are responsible for ensuring residents nails are kept clean, and the nurse is responsible for trimming his nails. Record review of the Admission Record revealed Resident #2 was admitted to the facility on 2/01/2018 with medical diagnoses that included Unspecified Dementia. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/02/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severely impaired cognition. Resident #21 During initial rounds on 1/5/2026 at 10:31 AM, Resident #21 was observed lying in bed wearing a hospital gown with a dried, brownish substance on the top right side of the gown, approximately softball-sized, consistent in appearance with food or possible emesis. The	M0610		

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M0610	Continued from page 9 resident also had visible scattered dark hair on her chin and long fingernails, approximately three-fourths of an inch (3/4") in length, with jagged edges. During an observation and interview on 1/5/2026 at 11:38 AM, CNA #1 confirmed Resident #21's gown had a dried, brownish substance on the top right side consistent in appearance with food or possible emesis, visible dark hair on her chin, and long, jagged fingernails. CNA #1 stated that Resident #21 typically had more facial hair than was present at the time, stating, "She must have been shaved recently because there are usually lots more." During an interview on 1/6/2026 at 3:53 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that CNAs are responsible for ensuring residents receive assistance, or total care if needed, with ADLs each morning, including bathing or hygiene care as needed, dressing, and grooming. The DON stated residents should not be left with visible grooming concerns, including soiled clothing, unaddressed facial hair, or long, jagged fingernails. She further stated that long, jagged fingernails pose a potential risk for infection related to skin tears and that wearing soiled clothing and female residents having unwanted facial hair are dignity concerns. Record review of the Admission Record revealed Resident #21 was admitted to the facility on 8/11/2025 with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS score of 00, indicating the resident had severely impaired cognition. Resident #24 Observation of Resident #24 on 1/5/26 at 11:00 AM, revealed that her fingernails on both hands were approximately one-fourth (1/4) inch past her fingertips and jagged. Interview with CNA #2 on 1/5/26 at 11:36 AM, she verified that Resident #24 had long jagged nails and she stated that she thought the shower team was responsible for cutting nails.	M0610		

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M0610	Continued from page 10 Interview with the DON she stated that the shower aid is responsible for nail care on shower days, but if the resident refused a shower the floor CNA should have cut the nails. She agreed that the nails were long and put Resident #24 at risk for injury. Record review of the "Admission Record" revealed that the facility admitted Resident #24 on 5/11/24 with a diagnosis of Cognitive Communication Deficit.	M0610		
M0615	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on staff interviews, record reviews, and facility policy reviews, the facility failed to ensure the prevention of an avoidable pressure injury (Resident #4), and delayed treatment for one (1) of seven (7) residents with pressure ulcers. (Resident #58) Findings include: Review of facility policy titled “Pressure Injury Prevention and Management,” with a review date of 11/7/2025, revealed, “Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.” Resident #4 Review of the “Wound-Weekly Observation Tool,” dated 8/18/25, revealed Resident #4 developed a suspected deep tissue Injury (SDTI) to the left (L) heel measuring 60 millimeters (mm) length x 50mm width x 1mm depth on 8/18/25. Review of the “Wound-Weekly Observation Tool,” dated 10/2/25, revealed the SDTI to left (L) heel had progressed to a Stage 3 pressure ulcer measuring 60mm length x 50mm width x 1mm depth, intact and mushy.	M0615		

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M0615	Continued from page 11 Review of the care plan revealed Resident #4 "…refused to be turned or repositioned every two (2) hours because it interferes with me watching T.V." The care plan did not include interventions to prevent the development of pressure ulcers. Review of the "Task List Report" revealed the task for off-loading of extremities was not initiated until 12/10/2025 and the wound was identified on 08/18/25 as a SDTI. During an interview on 1/6/2026 at 2:45 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that preventative measures were not implemented until 12/10/25. The DON stated her expectation was that preventative measures be implemented prior to the development of pressure ulcers. Record review of the Admission Record revealed Resident #4 was admitted to the facility on 2/1/2025 with medical diagnoses that included Other Lack of Coordination, Type 2 Diabetes Mellitus with Hyperglycemia, and Peripheral Vascular Disease, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 01, indicating the resident had severely impaired cognition. Resident #58 Record Review of the "Wound-Weekly Observation Tool," dated 9/15/25, revealed Resident #58 developed a Stage II pressure ulcer on sacrum, it is noted to have been identified on 9/13/2025. Record Review of orders to treat were received on 9/15/2025. Registered Nurse (RN) #1 received the physician orders and performed wound care. During an interview on 1/7/2026 at 3:00 PM with RN #1, she stated she was unaware of wound until 9/15/25. This resulted in a two-day delay in physician notification, obtaining treatment orders, and initiation of wound care for Resident #58's Stage II pressure ulcer. During an interview on 1/7/2026 at 4:10 PM, the DON and ADON confirmed that the wound should have been reported, orders obtained and treated the same day the	M0615		

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M0615	Continued from page 12 wound was identified and there should not be a delay in treatment. Record review of the Admission Record revealed Resident #58 was admitted to the facility on 9/04/2025 with medical diagnoses that included Giardiasis. Record review of the quarterly MDS with an ARD of 9/11/2025 revealed under Section C a BIMS score of 14, indicating no cognitive impairment.	M0615		
M0650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of seven (7) residents on fluid restrictions. Resident #7. Findings Included: Record review of the facility policy titled "Fluid Restriction" date reviewed 11/5/25 revealed "It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders…" Record review of the "Order Summary Report" for Resident # 7 revealed an active order, dated 7/11/2025 for fluid restriction 1000 cubic centimeters (CC). Total nursing 300cc nursing days, 120cc evening, 90cc night. Total dietary 700cc breakfast, 340cc lunch, 120cc supper -240cc." Record review of Resident #7's January 2026 Electronic Medical Record (Emar) and interview with Registered Nurse #2 (RN) on 1/7/26 at 9:45 AM, she stated that the resident was on a fluid restriction related to being on dialysis. She verified that there was no documentation of Resident #7's intake, but there should be. She agreed that the resident's intake should be monitored and documented to ensure that the fluid restriction is being followed. She stated that it is important to keep up with the resident's intake to ensure the resident did not have fluid overload. Interview with the Director of Nursing (DON) on 1/7/26 at 9:50 AM, she stated that it was her expectation that	M0650		

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M0650	Continued from page 13 the nursing staff would monitor and document the intake of a resident who has an order for a fluid restriction. Record review of the "Admission Record" revealed that the facility admitted Resident #7 on 2/24/23 with a diagnosis of End Stage Renal Disease.	M0650		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, staff interviews, record review, and facility policy reviews, the facility failed to implement infection prevention and control practices to prevent the transmission of infections. The facility failed to ensure that staff used Enhanced Barrier Precautions (EBP) during medication administration and failed to ensure oxygen delivery devices and wash basins were stored in a sanitary manner when not in use during three (3) of nine (9) resident care opportunities. (Residents #5, #9 and #21) Findings Include: Review of facility policy titled “Oxygen	M1570		

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M1570	Continued from page 14 Administration" with a review date of 11/7/2025, revealed, "…Policy Explanation and Compliance Guidelines…Keep delivery devices covered in plastic bag when not in use…" Review of facility policy titled "Enhanced Barrier Precautions (EBP)" with a review date of 11/13/2025, revealed, "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms…An order for enhanced barrier precautions will be obtained for residents with any of the following:…indwelling medical devices (e.g.…feeding tubes…even if the resident is not known to be infected or colonized with a multidrug drug resistant organism (MDRO)…" Review of facility policy titled "Safe and Homelike Environment" with a review date of 10/14/2025, revealed, "In accordance with residents' rights, the facility will.…preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes…equipment used in the completion of the activities of daily living…" Resident #5 During initial rounds on 1/5/2026 at 10:35 AM, Resident #5's nebulizer mask and Continuous Positive Airway Pressure (CPAP) mask were observed lying uncovered on the bedside table and not stored in a clean, protective bag, creating a risk for contamination of respiratory equipment. During an interview on 1/6/2026 at 3:59 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that all respiratory mask/cannula and tubing should be stored in a plastic bag when not in use. The DON stated that the tubing and masks being left out on the bedside table put Resident #5 at an increased risk for infection and was not an acceptable practice. She further stated that her expectations were that plastic storage bags should always be used when the masks/tubing was not in use. Record review of the Admission Record revealed Resident #5 was admitted to the facility on 6/12/2025 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified, and Hypertensive Heart Disease with Heart Failure. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/2025	M1570		

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M1570	Continued from page 15 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #9 During medication administration observation on 1/7/2026 at 10:00 AM, with Licensed Practical Nurse (LPN) #3, revealed that LPN #3 failed to follow infection control procedures for EBP during medication administration through Resident #9's feeding tube. LPN #3 confirmed she forgot to wear the gown during medication administration and stated that EBP should have been used due to Resident #9 having a feeding tube to help prevent the possible spread of infection. During an interview on 1/7/26, the DON confirmed that EBP should have been used during medication administration since Resident #9 had a feeding tube used for feeding and medication administration. She verbalized that EBP was to be used as ordered for the prevention of infection. Record review of the Admission Record revealed Resident #9 was admitted to the facility on 12/8/2025 with medical diagnoses that included Cerebral Infarction, Unspecified. Record review of the quarterly MDS with an ARD of 12/15/2025 revealed under Section C that a BIMS was not assessed. Resident #21 During initial rounds on 1/5/2026 at 10:35 AM, observation of five (5) wash basins that were stored directly on Resident #21's bathroom floor, uncovered and not stored in a bag or container. During an interview on 1/7/2026 at 1:55 PM, the Director of Nursing (DON) confirmed that reuseable bath basins should be labeled with the resident's name and stored in a bag or container off the floor for infection control purposes. Record review of the Admission Record revealed Resident #21 was admitted to the facility on 8/11/2025 with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS score of 00,	M1570		

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M1570	Continued from page 16 indicating the resident had severely impaired cognition.	M1570		