STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	**310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with three (3) Complaint Investigations (CI MS #2678122, CI MS #2679003, and CI MS #2711846) at the facility from 1/20/26 through 1/22/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated CI MS #2678122 for neglect and quality of care related to staff refusing to provide care, CI MS #2679003 related neglect and quality of care for not being groomed adequately, and CI MS # 2711846 related to neglect and quality of care and cited F677 for Activities of Daily Living. During the recertification survey the SA cited F584, F656, F688, F761, F812, and F842. The census at the time of the survey was 81 with a license for 120 beds.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's wheelchair was maintained in a safe manner for one (1) of 68 residents requiring a standard wheelchair for locomotion. Resident #12 Findings Include: Review of the facility policy titled “Preventative Maintenance for Wheelchairs” undated, revealed under, “Policy: It is the practice of this facility to develop and implement a preventative maintenance program to ensure wheelchairs are maintained in a safe and operable manner.” Also revealed under, “Policy Explanation and Compliance Guidelines: … 4. Preventative maintenance should be performed weekly or as indicated: … e. Check seats, backs, arm rest and cushions for tears, cracks or missing screws-replace or repair if present.” An observation and interview on 1/20/26 at 11:10 AM, revealed Resident #12 seated in her wheelchair with significant damage to both armrests. Each armrest was split in half, exposing the hard gray plastic interior. The black vinyl armrest covering was torn and hanging	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0584 SS = D	Continued from page 2 loosely from the sides, and a protruding silver screw was visibly present on the right armrest. The resident's arms were resting directly on the exposed plastic. She stated staff knew about the condition of the wheelchair and that the chair had been like that for a while. An observation and interview with the Administrator on 1/21/26 at 3:53 PM, revealed her expectations were for residents to have safe, operating equipment in good repair. She explained that aides were responsible for reporting broken or damaged equipment in the maintenance log so repairs could be made. The Administrator confirmed Resident #12 had broken wheelchair armrests in poor condition which could cause skin concerns. Record review of the "Admission Record" revealed the facility admitted Resident #12 on 8/12/24 with diagnoses that included Schizoaffective Disorder, Bipolar Type, and Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #12 was cognitively intact.	F0584		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0656 SS = D	Continued from page 3 §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review the facility failed to implement a comprehensive care plan related to applying a hand splint (Resident #61) and nail care (Resident #66, and #89) for three (3) of twenty four care plans reviewed. Findings include: Review of the facility care plan policy titled, "Comprehensive Care Plan" with a revision date of 4/2025, revealed "It is the standard of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment."	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0656 SS = D	Continued from page 4 Resident #66 Record review of Resident #66's "Care Plan Report" revealed "Focus: (Proper name of Resident #66) has an ADL (Activities of Daily Living) self care performance deficit r/t (related to) increased weakness and limited mobility". Listed under "Interventions/Tasks" was "Personal Hygiene/oral care: He requires set up and clean up assistance from 1 (one) staff to complete personal hygiene and oral care". During an interview and observation on 1/20/26 at 12:40 PM, Resident #66 revealed he liked his nails kept short and smooth and would like for them to be trimmed. Nails were observed to be approximately 1/4 inch from nail bed with a brown substance under several nails noted. Nails were jagged and rough in multiple areas. On 1/21/26 at 3:50 PM, during an interview and observation, the Director of Nursing revealed her expectation was for each dependent resident to receive personal hygiene which included nail care and acknowledged that Resident #66's nails were long, dirty, and jagged. She confirmed the facility failed to maintain a resident's nails at an appropriate and safe length and in clean condition and therefore did not follow the care plan for assistance with activities of daily living care. During an interview on 1/22/26 at 10:20 AM, the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator revealed the purpose of the care plan was to inform the staff of the needs of the residents so these needs could be met. She acknowledged that nail care was a part of personal hygiene and was to be performed for the dependent residents. She confirmed the care plan for personal hygiene for nail care was developed but not implemented. Record review of "Admission Record" revealed the facility admitted Resident #66 on 12/15/2020 with a diagnosis of Metabolic Encephalopathy. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/6/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0656 SS = D	Continued from page 5 Resident #89 Record review of Resident #89's "Care Plan Report" revealed Resident #89 has a functional abilities (Self-care and mobility) deficit related to impaired balance and musculoskeletal impairment." Under Interventions…Personal Hygiene: She is dependent on 2 assistant to maintain personal hygiene. On 1/20/2026 at 2:55 PM, an observation and interview revealed Resident #89's fingernails were approximately one (1) inch long and jagged with a brown substance under them. Resident #89 revealed that she would like her fingernails to be trimmed and cleaned. On 1/21/2026 at 1:20 PM, an observation of Resident #89's fingernails remain long and jagged with a brown substance underneath them. During an interview and observation on 1/21/2026 at 3:50 PM, Certified Nurse Aide (CNA) #1 revealed we are responsible for cleaning the resident's fingernails when we clean them up each morning. She revealed the wound treatment nurse is responsible for cutting the nails if they are diabetic. CNA #1 confirmed that Resident #89's fingernails were long and jagged and stated, "they are definitely dirty and need a good trimming." During an interview and observation on 1/21/2026 at 4:05 PM, the Director of Nurses (DON) revealed it is the responsibility of the CNA's to clean the residents' fingernails when they are providing daily care, and the nurses are responsible for ensuring the fingernails are adequately trimmed. The DON confirmed that Resident #89's fingernails were long and dirty, which could cause a skin tear and a possible infection. The DON confirmed that the resident's plan of care for her personal hygiene was not being followed and it should have been. Record review of the "Admission Record" revealed that Resident #89 was admitted to the facility on 01/08/2026 with diagnoses that included a displaced oblique fracture of the shaft of the right ulna and muscle weakness.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0656 SS = D	Continued from page 6 Record review of the MDS Section C with an ARD of 1/15/2026 revealed a BIMS score of 8, which indicated Resident #89 has moderate cognitive impairment. Resident #61 Record review of Resident #61's Care Plans revealed under, "Focus: (Proper name of Resident #61) has an ADL (activity of daily living) Self Care Performance Deficit r/t (related to) Stroke." Also revealed under, "Intervention: She has contractures of bilateral hands, wash and dry bilateral hands, provide PROM (passive range of motion). Apply bilateral hand splints. Resident to wear bilateral hand splints for 8 hrs (hours) daily." During an observation of Resident #61 on 1/20/26 at 10:40 AM, she was lying in bed without hand splints. A hand/wrist splint was lying on the bedside dresser. An interview with a family member revealed staff did not apply them. On 1/21/26 at 9:48 AM, an observation of Resident #61 revealed there were no hand splints in place. On 1/22/26 at 8:36 AM, an observation revealed Resident #61 without hand splints. On 1/22/26 at 8:43 AM, an interview with Licensed Practical Nurse (LPN) #2 (Restorative Nurse) confirmed Resident #61's hand splints were not being applied as ordered. An interview with the Minimum Data Set (MDS) Nurse on 1/22/26 at 9:57 AM revealed the purpose of the care plan was to notify the staff of what care to provide for the residents. She confirmed Resident #61's care plan was not followed for the splints and stated there was a break in communication. Record review of the "Admission Record" revealed the facility admitted Resident #61 on 2/26/24 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Middle Cerebral Artery and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed under section C, Resident #61's cognitive skills for daily decision making were severely impaired.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0677 SS = D	Continued from page 7 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide personal hygiene for two (2) of the twenty-one sampled residents. Resident #66 and Resident #89. Findings include: A review of the facility policy titled, "Resident Hygiene Care of Fingernails/Toenails" with a revision date of 6/2022, revealed "The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. Nail care includes cleaning and trimming as needed. Proper nail care can aid in the prevention of skin problems around the nail bed." Resident #89 On 1/20/2026 at 2:55 PM, an observation and interview revealed Resident #89's fingernails were approximately one (1) inch long and jagged with a brown substance under them. Resident #89 revealed that she would like her fingernails to be trimmed and cleaned. On 1/21/2026 at 1:20 PM, an observation of Resident #89's fingernails remain long and jagged with a brown substance underneath them. During an interview and observation on 1/21/2026 at 3:50 PM, Certified Nurse Aide (CNA) #1 revealed we are responsible for cleaning the resident's fingernails when we clean them up each morning. She revealed the wound treatment nurse is responsible for cutting the nails if they are diabetic. CNA #1 confirmed that Resident #89's fingernails were long and jagged and stated, "They are definitely dirty and need a good trimming." During an interview and observation on 1/21/2026 at 4:05 PM, the Director of Nurses (DON) revealed it is	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0677 SS = D	Continued from page 8 the responsibility of the CNA's to clean the residents' fingernails when they are providing daily care, and the nurses are responsible for ensuring the fingernails are adequately trimmed. The DON confirmed that Resident #89's fingernails were long and dirty, which could cause a skin tear and a possible infection. Record review of the "Admission Record" revealed that Resident #89 was admitted to the facility on 01/08/2026 with diagnoses that included a displaced oblique fracture of the shaft of the right ulna and muscle weakness. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 1/15/2026 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #89 has moderate cognitive impairment. Resident #66 During an interview and observation on 1/20/26 at 12:40 PM, Resident #66 revealed he liked his nails kept short and smooth and would like for them to be trimmed. Nails were observed to be approximately 1/4 inch from nail bed with a brown substance under several nails noted. Nails were jagged and rough in multiple areas. On 1/21/26 at 3:50 PM, during an interview and observation, the Director of Nursing revealed her expectation was for each dependent resident to receive personal hygiene which included nail care. She acknowledged that Resident #66's nails were long, dirty, and jagged with sharp areas that could cause an injury to the skin. She confirmed the facility failed to maintain a resident's nails at an appropriate and safe length and in clean condition. Record review of "Admission Record" revealed the facility admitted Resident #66 on 12/15/2020 with diagnosis of Metabolic Encephalopathy. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/6/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment.	F0677		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0688 SS = D	Continued from page 9 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, family and staff interview, record review, and facility policy review, the facility failed to ensure prescribed splinting devices were applied as ordered for one (1) of (35) residents reviewed for range of motion impairments. Resident #61 Findings Include: Record review of the facility policy titled "Restorative Nursing Standard" with a revision date of 3/19 revealed under, "4. Splints … Its purpose is to prevent deformities when an increase of tone is noted in hand and occasionally with a flaccid hand..." On 1/20/26 at 10:40 AM, an observation of Resident #61 revealed she was lying in bed, nonverbal, with her eyes open. A hand/wrist splint was lying on the bedside dresser. She had contractures to both hands, with the left worse than the right. A soft hand roll was inside the left hand. An interview with a family member during this time revealed therapy previously applied hand splints to both hands; however, she no longer received therapy, and staff did not apply them. The family member stated he applies the right-hand splint for about an hour a day but does not apply the left-hand splint, confirming the resident still had both splints in the dresser drawer.	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0688 SS = D	Continued from page 10 An observation of Resident #61 on 1/21/26 at 9:48 AM, revealed there were no hand splints in place. Her left hand held a soft hand roll. Record review of Resident #61's "Progress Notes" dated 3/14/24 revealed a Restorative Care Referral was made to apply bilateral hand splints for 8 hours daily. Record review of Resident #61's "Kardex" revealed under, "Restorative: …She has contractures of bilateral hands, wash and dry bilateral hands, provide PROM. (passive range of motion). Apply bilateral hands splints. Resident to wear bilateral hand splints for 8 (eight) hrs. (hours) daily." An interview with Certified Nurse Aide #2 on 1/22/26 at 8:34 AM, revealed she did not apply hand splints for Resident #61 and stated restorative was responsible. An observation on 1/22/26 at 8:36 AM, revealed Resident #61 without hand splints, with her left hand holding a soft hand roll. An interview with Licensed Practical Nurse (LPN) #2 (Restorative Nurse) on 1/22/26 at 8:43 AM, revealed the facility did not have a restorative program but was working to obtain staff to restart the program. She confirmed she did not apply Resident #61's splints and was not aware the resident was supposed to wear them. She stated she knew family was applying a splint at one time and confirmed if splints were not being applied as ordered, the contractures could worsen. An interview with the Rehabilitation Director on 1/22/26 at 9:10 AM, revealed the last time Resident #61 received occupational therapy for contractures and splinting was in February 2024. She revealed the resident was referred to restorative for splinting shortly thereafter and was screened quarterly with no changes in function identified. She confirmed if staff were not applying Resident #61's hand splints, her contractures could worsen. Record review of the "Admission Record" revealed the facility admitted Resident #61 on 2/26/24 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Middle Cerebral Artery and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed under section C, Resident #61's cognitive skills for daily decision making were severely impaired.	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0688 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: During observation, staff interviews, and facility policy/document review, the facility failed to ensure medications were secured properly to prevent unauthorized access for one (1) of three (3) days of survey. Findings include: Review of a “Med Pass” check off list with no date, revealed, “…Medications locked within the cart when cart is out of direct line of vision…” There was signature line for both the learner and observers’ signature on the document. An observation on 1/20/2026 at 8:14 AM revealed an unlocked and unattended medication cart on the 200 unit with residents wandering in the immediate area. The medication cart contained various respiratory treatment medications used by the Respiratory Therapist.	F0688 F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0761 SS = D	Continued from page 12 During an interview on 1/20/2026 at 8:15 AM, the Respiratory Therapist (RT) confirmed the medication cart was left unlocked and unattended. He further confirmed residents were wandering on the unit while the cart remained unlocked and unattended. He stated the importance of ensuring medications are stored in a locked cart or locked medication room and identified residents could be at risk if they accessed the unlocked cart. During an interview on 1/20/2026 at 10:30 AM, the Administrator confirmed all medication carts should be locked at all times unless in active use, particularly when left unattended. She further confirmed there was a risk if a resident accessed an unlocked medication cart.	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to maintain food service areas in a sanitary manner to prevent the potential for food contamination. Specifically, the facility failed to ensure ventilation ductwork was free	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0812 SS = F	Continued from page 13 from a black mold-like substance in areas located above food preparation and food storage locations on two (2) of (2) kitchen tours. Findings include: Review of facility policy titled “Sanitation and Infection Control” with no date, revealed, “Standard: …to ensure sanitary conditions…in the dining service department…” On 1/20/2026 at 10:21 AM, during an initial tour of the facility kitchen accompanied by the Dietary Manager revealed an observation of a black mold-like substance on the ventilation ductwork above the stove, with visible dark discoloration along the seams and underside of the duct. A similar black mold-like substance was also observed on the ductwork in the dry storage room, extending along multiple sections of the duct. Both locations were in close proximity to food preparation and food storage areas. The Dietary Manager confirmed the substance had been present for several months. During an observation of the ductwork in the kitchen on 1/20/2026 at 11:38 AM, with the Plant Operations Manager, he confirmed the presence of a black mold-like substance on the ductwork above the stove and food preparation areas and on the ductwork in dry storage room, which he stated increased the risk for food contamination. During an interview with the Administrator on 1/20/2026 at 3:30 PM, she confirmed there was a risk for foodborne illness related to the presence of the black mold-like substance above the stove and food preparation areas.	F0812		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0842 SS = D	Continued from page 14 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0842 SS = D	Continued from page 15 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to ensure medications were accurately labeled and corresponded with the physician's order for two (2) of three (3) residents observed during medication pass. (Resident #5 and #20). Findings Include: Review of the pharmacy's policy titled "Long Term Care Facilities/Pharmacy Operations/Medication Packaging: Strip Packaging" with review date 04/2023, revealed: "Strip packaging is provided for efficient and accurate medication administration and accountability of routine oral solid medications...Remember to always check your MAR prior to administering medications…" Resident #5 An observation during medication pass on 1/20/2026 at 9:44 AM revealed Licensed Practical Nurse (LPN) #5 retrieved a pharmacy-prepared multi-dose pouch labeled Omeprazole Oral Tablet Delayed Release 40 milligrams (mg) from the medication cart, opened the pouch and retrieved one (1) tablet, and administered it by mouth to Resident #5 along with other morning medications. During this observation, the January 2026 Medication Administration Record (MAR) did not match the Omeprazole Oral Tablet Delayed Release 40 mg tablets on hand in the multi-dose pouch, revealing a discrepancy between the physician's order and the labeled	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0842 SS = D	Continued from page 16 medication for Resident #5. Record review of Resident #5's January 2026 MAR revealed an order dated 8/22/2023 for "Omeprazole Oral Tablet Delayed Release 20 mg, Give (2) tablets by mouth one time a day for Gastroesophageal Reflux Disease (GERD)." Review of Resident #5's pharmacy-prepared multi-dose pouch dated for 1/20/2026 morning medication administration revealed, " Omeprazole Oral Tablet Delayed Release 40 mg Give (1) tablet by mouth one time a day for GERD." During an interview on 1/20/26 at 9:45 AM, LPN #5 confirmed Resident #5's physician order and medication label did not match. She stated the discrepancy had been present for some time and stated, “I’ve never thought to get it changed.” During an interview on 1/20/26 at 2:30 PM, the Director of Nursing (DON) acknowledged the labeling inaccuracy created the possibility a nurse could administer an incorrect dose. She stated she was unaware of the discrepancy and that nursing staff should have reported so it could have been corrected. Record review of Resident #5's "Face Sheet" revealed the facility admitted the resident on 8/21/2023 with diagnoses including Metabolic Encephalopathy and Gastro-Esophageal Reflux Disease without Esophagitis. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/25 under section C revealed a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated Resident #5 was cognitively intact. Resident #20 An observation during medication pass on 1/20/26 at 8:22 AM revealed LPN #4 retrieved a pharmacy-prepared multi-dose pouch labeled Desmopressin Acetate Tablet 0.2 mg from the medication cart, opened the pouch and retrieved (1) tablet, and administered it via Percutaneous Endoscopic Gastronomy (PEG) tube to Resident #20 along with other morning medications. During this observation, the MAR did not match the Desmopressin Acetate Tablet 0.2 mg tablets on hand in the multi-dose packet, revealing a discrepancy between the physician order and the labeled medication for Resident #20. Record review of Resident #20's January 2026 MAR	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702

(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
F0842 SS = D	Continued from page 17 revealed an order dated 5/6/2020, "Desmopressin Acetate Tablet 0.1 mg. Give (2) tablets via PEG-Tube three times a day for diabetes insipidus." Review of Resident #20's pharmacy-prepared multi-dose pouch dated for 1/20/2026 AM medication administration revealed, " Desmopressin Acetate Tablet 0.2 mg Give one (1) tablet via PEG-Tube three times a day and Baclofen Tablet 10 mg Give 0.5 tablet via PEG-Tube two times a day for seizures." An interview with LPN #4 on 1/20/26 at 8:22 AM, confirmed Resident #20's physician order and medication label did not match. She stated this discrepancy could easily cause a nurse to administer the wrong amount. She further stated that the facility changed pharmacy providers a few months ago and she had noticed the variations but had not notified anyone to have the issue corrected. An interview with the DO) on 1/20/26 at 2:30 PM, acknowledged that the labeling inaccuracy created the possibility that a nurse could administer an incorrect dose. She stated she was unaware of the discrepancy, and the nurse should have reported so it could have been corrected. Record review of Resident #20's "Face Sheet" revealed the facility admitted the resident on 8/30/2019 with diagnoses including Unspecified Intracranial Injury with loss of consciousness of unspecified duration, subsequent encounter and Persistent Vegetative State. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/25 revealed under section C that the BIMS was conducted by staff assessment for daily decision making and were coded as (3) indicating severely impaired-never/rarely made decisions.	F0842		