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 **01/22/2026**

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

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M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. 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 M610 for Activities of Daily Living. During the recertification survey the SA cited M625 and M815.	M0000		
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, 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	M0610		

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

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M0610	Continued from page 1 #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 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.	M0610		

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M0610	Continued from page 2 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.	M0610		
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE 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	M0625		

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M0625	Continued from page 3 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. 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	M0625		

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M0625	Continued from page 4 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.	M0625		
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 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 from a black mold-like substance in areas located above food preparation and food storage locations on two (2) of two (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, the surveyor conducted an initial tour of the facility kitchen accompanied by the Dietary Manager. The surveyor observed 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	M0815		

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M0815	Continued from page 5 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.	M0815		