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 **02/11/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	**101 CUNNINGHAM DR , RIPLEY, Mississippi, 38663**

(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 at facility from 2/8/26 through 2/11/26. 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 and cited, M225, M500, M610, M615, and M1570. The census at the time of the survey was 122 and the facility is licensed for 140 beds.	M0000		
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more	M0225		

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

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M0225	Continued from page 1 shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interviews, record review, staffing schedule review, and Payroll Based Journal (PBJ) staffing data report review, the facility failed to provide sufficient nursing staff to meet the needs of residents for six (6) of 119 residents and five (5) of 77 occupied rooms in the facility. This resulted in delayed call light response times, delayed toileting and incontinence care, and delayed assistance with activities of daily living for multiple residents, placing residents at risk for unmet care needs, skin breakdown, falls, and decreased quality of life. Resident #28, Resident #75, Resident #94, Resident #103, Resident #116, and Resident #122. Findings include:	M0225		

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M0225	Continued from page 2 The facility provided a statement on letterhead, signed by the administrator which read, “It is the practice of [Proper name of the facility]to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Staffing expectations are based on resident acuity and needs and may fluctuate based on the center population as identified in the facility assessment...” Record review of the “PBJ Staffing Data Report” revealed the facility triggered for excessively low weekend staffing for the fourth quarter (July 1 – September 30, 2025). Record review of the “Center Assessment Tool” dated 6/18/25, revealed the facility identified a need for 13-15 licensed nursing staff providing direct care daily and 25-35 nurse aides on average over a 24-hour period. Review of the posted “Daily Nurse Staffing Form” dated 2/8/26 revealed a resident census of 123 and the following: Day Shift: 1 Registered Nurse, 5 Licensed Practical Nurses, and 9 Certified Nurse Aides Evening Shift: 1 Registered Nurse, 5 Licensed Practical Nurses, and 7 Certified Nurse Aides Night Shift: 1 Registered Nurse, 2 Licensed Practical Nurses and 5 Certified Nurse Aides Further review of the “Daily Nurse Staffing Form” revealed the facility scheduled a total number of 21 nurse aides over a 24-hour period, which did not meet the facility’s assessed need of 25-35 nurse aides, as identified in the Center Assessment Tool dated 6/18/25. An observation and interview on 2/8/26 at 2:40 PM with Resident #103 revealed she was an obese female and dependent on staff for her Activities of Daily Living needs. She stated that sometimes she remained wet for up to two hours before the aides changed her and stated, "I have wet through my brief, gown, and bed pad before." Resident #103 revealed that they needed more aides to work on the halls and answer call lights. She explained that when she pushed her call light, it takes them sometimes two hours to come in and see what she	M0225		

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M0225	Continued from page 3 needed and voiced sometimes there was only one CNA working an entire hall. She also revealed that she had to wait over an hour for her call light to be answered on average two to three times a week, and more commonly on the 3PM to 11PM shift. During initial tour on 2/8/2026 at 3:26 PM, Resident #28 stated that staffing was noticeably short on weekends and sometimes at night. He explained that on Wednesday night he woke up at 2:30 AM and had soiled his brief. He stated he pressed the call light and had to wait 55 minutes for someone to come and change him. He stated that he did report it to the nurse on duty. An interview on 2/8/26 at 3:30 PM with Resident #75 revealed that it took a long time to get someone to answer the call light. She explained that she did not like to get up into the wheelchair because staff would just leave her sitting in her room and would not answer the call light when she wanted to lie down. Further interview with a family member in the room revealed the call light sounded on average for 30-45 minutes and he frequently had to go get someone to answer the light. During initial tour on 2/8/26 at 3:43 PM, Resident #116 stated that weekend staffing was always short. He further stated that they had to wait longer than usual for help or to receive care. He stated that the staff would apologize for the excessive wait, stating "we are working short." An observation of Resident #94's room on 2/8/26 at 4:26 PM revealed call light had sounded for approximately 12 minutes. A Certified Nurse Aide (CNA) observed passing ice and a nurse giving medications on the hall but neither responded. Upon entry to the room the resident stated she needed to be changed and was wet. Further interview revealed she had waited up to an hour before to be changed and guessed they (the facility) did not have enough help. An interview with Resident #122 on 2/8/26 at 5:30 PM revealed call light response time was a big concern. She stated some of the staff come and tell her, “It's going to be awhile” and others just let her wait without knowing. Resident #94 stated she had waited up to an hour to be changed and revealed the incontinence briefs cannot hold up long when it was wet.	M0225		

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M0225	Continued from page 4 An observation on A hall on 2/8/26 at 5:40 PM revealed a nurse seated at the nurses' station and another standing at the medication cart while multiple call lights were audibly sounding. Call lights were observed sounding from rooms A2, A5, A6, A9, and A12 with no staff response for approximately 15-20 minutes. During an observation and interview with Licensed Practical Nurse (LPN) #1 on 2/8/26 at 6:03 PM she confirmed multiple resident call lights were sounding and that she did not stop medication pass to address the residents' needs. She stated, "Everyone is responsible for answering the call lights." LPNs #1 revealed she was unsure how many aides were assigned to A hall and since her shift began, she had only seen one aide working. She revealed that when call lights go unanswered the residents get delayed care and they might decide to get up by themselves and fall. An observation and interview with Certified Nurse Aide (CNA) #7 on 2/8/26 at 6:07 PM confirmed she was working A hall and was aware of multiple call lights sounding stating "I've seen them." She revealed that she was in a room and was unsure where the other aide was that had the split section. She confirmed call lights should be answered in a timely manner stating, "Anything could happen to them (the resident)." An interview with CNA #5 on 2/9/26 at 12:15 PM confirmed that she worked day shift and weekends. She revealed today she had the split section of A hall and revealed it was difficult to keep track of the call lights with two halls. CNA #5 confirmed that the residents had complained about the slow call light response time and revealed it was hard to stop caring for one resident to answer another call light. CNA #5 revealed she had 16 residents to care for today, but the total changed depending on what hall they were working. She revealed call ins were the issue on the weekends, and the facility tried to find replacements, but nobody wants to work on the weekends. An interview with CNA #4 on 2/9/26 at 12:20 PM revealed she worked day shift and weekends. She revealed call ins were the issue on the weekends and stated they (the aides) had worked with one aide to an entire hall before. She stated when that happens the medication cart nurse will come help them when they finish passing medications.	M0225		

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M0225	Continued from page 5 An interview with CNA #6 on 2/10/26 at 10:25 AM revealed they were always short staff on the weekends due to call ins. She stated they have worked one aide to an entire hall before which would mean they were responsible for 28-30 residents. She explained they were responsible for getting the residents up, bathing, dressing, changing, toileting, turning, answering call lights, passing trays and assisting the residents with meals. She revealed the nurses do help when they can, but it can be overwhelming to know you have eight (8) hours to get the job done. An interview with the Workforce Manager Coordinator (WMC) on 2/10/26 at 11:05 AM revealed she was responsible for scheduling the aides and the Director of Nursing scheduled the nurses. She explained that she used a template provided by corporate to determine staffing numbers based on the census and by considering the acuity of the residents. The WMC revealed she scheduled enough staff for the weekends and call ins were the problem. She explained they have on call nurses that take call from Friday until Monday and were responsible for calling around to find staff when someone called in. During an interview on 2/10/26 at 11:42 AM, the Administrator (ADM) stated he was aware the facility had dropped below the expected staffing hours per patient day (PPD) on several days. He stated the facility was actively attempting to recruit staff and was offering bonuses and shift differentials to employees. The Administrator acknowledged call light response time was a concern and stated his expectation was that any staff member could answer a resident call light. He further acknowledged this had resulted in delays in care and unmet care needs for the residents. On 2/10/26 at 2:50 PM, during an interview with CNA #3, she stated the facility has had issues in the past with CNA call-ins on the weekends. She reported that staff have been asked to work double shifts to cover staffing shortages. CNA #3 further stated that a significant issue was that nurses do not assist with call lights. She explained that staff may be in a resident room providing care while a call light was sounding, and when they exit the room, a nurse may be sitting at the nurse’s station who could have answered the call light. CNA #3 stated that care would go much better if staff worked together as a team and believed residents would be happier if call lights were answered timely.	M0225		

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M0225	Continued from page 6 Record review of the “Admission Record” revealed the facility admitted Resident #28 on 11/20/25 with medical diagnosis that included Unspecified Sequelae of Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #28 was moderately cognitively impaired. Record review of the “Admission Record” revealed the facility admitted Resident #75 on 2/7/25 with medical diagnosis that included Pancytopenia. Record review of the MDS with an ARD of 12/22/25 revealed under section C, a BIMS score of 9, indicating Resident #75 was moderately cognitively impaired. Record review of the “Admission Record” revealed the facility admitted Resident #94 on 9/11/23 with medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side. Record review of the MDS with an ARD of 12/5/25 revealed under section C, BIMS score of 15, indicating Resident #94 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #103 on 6/3/24 with medical diagnosis that included Chronic Venous Hypertension with Ulcer of Right Lower Extremity. Record review of the MDS with an ARD of 12/4/25 revealed under section C, BIMS score of 15, indicating Resident #103 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #116 on 5/24/25 with medical diagnosis that included Alcoholic Cirrhosis of Liver without Ascites. Record review of the MDS with an ARD of 1/2/26 revealed	M0225		

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M0225	Continued from page 7 under section C, BIMS score of 14, indicating Resident #116 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #122 on 11/11/24 with medical diagnosis that included Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 2/2/26 revealed under section C, BIMS score of 14, indicating Resident #122 was cognitively intact.	M0225		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after	M0500		

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M0500	Continued from page 8 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 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;	M0500		

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M0500	Continued from page 9 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); 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:	M0500		

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M0500	Continued from page 10 Level II Based on record review, staff interview, and facility policy review, the facility failed to ensure concerns voiced during Resident Council meetings were addressed and resolved to residents' satisfaction in accordance with the requirements. Specifically, the facility failed to effectively respond to and resolve ongoing food-related concerns, including meals served cold and meats described as too tough to chew, which were repeatedly documented in Resident Council meeting minutes from August 2025 through December 2025, placing residents at risk for continued dissatisfaction for five (5) of six (6) months reviewed. Findings include: Review of facility policy titled, Customer Concern (Grievance) Policy with revised date: October 2024, revealed, "Purpose: Support each customer's (patient's/responsible party's/family's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately apprised of its progress toward resolution…Customer concerns will have a prompt response…". A Resident Council meeting was held in dining room on 2/10/2026 at 11:00 AM. A total of nine (9) residents were in attendance. Seven (7) of the nine (9) residents present expressed concerns regarding the food, stating the meals are often cold and certain meats are too tough to chew. Residents stated these concerns have been ongoing for several months. Record review of Resident Council Minutes dated 8/13/2025 at 2:00 PM revealed documented concerns including pork chops described as tough; breakfast items inconsistent with the posted menu; food reported as cold and lacking seasoning; fish described as not as good as previously served; and residents not being served a complete breakfast. Documentation under Old Business reflected pork chops described as too tough or undercooked and incomplete breakfast service, with the issue noted as not resolved to residents' satisfaction. Under New Business, similar concerns were documented, with 10 to 12 residents sharing concerns regarding tough pork chops, menu inconsistencies, cold food, and food quality. Record review of Customer Concern/Grievance Communication Form dated 8/13/2025, revealed "…Residents voiced in meeting that…Fish is not as good	M0500		

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M0500	Continued from page 11 as it used to be…Food is cold when received and don't have seasoning on it…Pork chop is still too tough to eat and enjoy…". Record review of Resident Council Minutes dated 9/10/2025 at 2:00 PM revealed Old Business concerns of tough pork chops, cold food, and fish quality were documented as not resolved to residents' satisfaction. New Business documented ongoing concerns, with nine (9) to twelve (12) residents reporting tough pork chops, cold food, overcooked fish, melted ice cream, and cold soup items at the time of service. Record review of Customer Concern/Grievance Communication Form dated 9/10/2025, revealed, "…Pork Chop is still too tough. Food is often cold. Fish is thin and fried too hard. Ice cream is always melted when received. Soup additives on trays are ice (fridge) cold…". Record review of Resident Council Minutes dated 10/8/2025 at 2:00 PM revealed New Business concerns that meal trays were frequently delivered late, resulting in residents missing scheduled activities or allowing food to sit before consumption. Ten (10) residents shared concerns regarding tough pork chops, cold hall trays upon receipt, and melted ice cream. Record review of Customer Concern/Grievance Communication Form dated 10/8/2025, revealed, "…Pork Chop still too tough, can't chew. Hall food trays are still cold sometimes when received. Ice cream is still melted when received…". Record review of Resident Council Minutes dated 11/12/2025 at 2:00 PM revealed Old Business concerns regarding melted ice cream were documented as not resolved. New Business documented concerns including fried chicken described as overly hard, meals reported as cold upon receipt, and ice cream described as soft or melted. Record review of Customer Concern/Grievance Communication Form dated 11/12/2025, revealed, "…Ice cream still soft and melted…". Record review of Resident Council Minutes dated 12/29/2025 at 11:00 AM revealed documentation that ice cream consistency had improved; however, Old Business reflected fried chicken described as too hard and meals described as cold remained unresolved. New Business documented six (6) to eleven (11) residents reporting concerns of hard fried chicken, cold food at the time of service, and pork chops described as hard and not	M0500		

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M0500	Continued from page 12 tender. Record review of Customer Concern/Grievance Communication Form dated 12/29/2025, revealed "…Residents stated that their food when received is often cold or not at a desired temp to enjoy…". During an interview on 2/10/2026 at 4:00 PM, the Administrator stated he was aware of the ongoing food-related complaints and that a new Dietary Manager had been hired and started approximately one week prior. He stated she had previously worked for the facility and food service was something that they were working to improve but confirmed that the previous resident grievances were unresolved. Record review of the "Admission Record" indicated that the facility admitted Resident #9 on 11/7/2022 with a medical diagnosis that included Cellulitis of Right Finger, End Stage Renal Disease, and Type 2 Diabetes Mellitus without Complications. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/25 revealed under section C, a Brief Interview for Mental Status "BIMS" summary score of 14 which indicated Resident #9 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #19 on 5/20/2022 with a medical diagnosis that included Paraplegia, Incomplete and Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. A record review of the MDS with an ARD of 11/17/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #19 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #37 on 12/2/2025 with a medical diagnosis that included Other Displaced Fracture of Upper End of Left Humerus, Subsequent Encounter for Fracture with Routine Healing, Incomplete and Type 2 Diabetes Mellitus without Complications. A record review of the MDS with an ARD of 12/9/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #37 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #49 on 2/10/2025 with a medical diagnosis that included Acute on Chronic Diastolic (Congestive) Heart Failure and Type 2 Diabetes Mellitus without Complications.	M0500		

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M0500	Continued from page 13 A record review of the MDS with an ARD of 11/13/25 revealed under section C, a BIMS summary score of 9 which indicated Resident #49 had moderately impaired cognition. Record review of the "Admission Record" indicated that the facility admitted Resident #64 on 8/10/2024 with a medical diagnosis that included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of the MDS with an ARD of 11/5/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #64 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #94 on 9/11/2023 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side. A record review of the MDS with an ARD of 12/5/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #94 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #100 on 2/5/2019 with a medical diagnosis that included Other Specified Arthritis, Multiple Sites. A record review of the MDS with an ARD of 11/28/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #100 was cognitively intact.	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 14 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident who required assistance received activities of daily living (ADL) care, including grooming and personal hygiene services such as shaving, in accordance with the resident's assessed needs, for one (1) of 21 residents. (Resident #111) Findings Include: Review of facility policy titled "ADLs (Activities of Daily Living)", with an effective date of August 2021, revealed the facility policy is to ensure activities of daily living are provided in accordance with accepted standards of practice, the resident's care plan, and reasonable accommodation of the resident's choices and preferences. The policy further identified hygiene activities of daily living to include bathing, dressing, grooming, and oral care. During an interview and observation on 2/09/2026 at 8:20 AM, Resident #111 stated he doesn't get shaved all the time when he is supposed to. "They do it when they take a notion to do it." Resident #111 has facial hair approximately one (1) inch on his cheeks, above his upper lip, and on his chin. The resident stated, "I can't tell you when the last time it was done." During an interview and observation on 2/09/2026 at 12:15 PM, Certified Nurse Aide (CNA) #1 revealed the resident usually gets shaved when he gets his bath which is on Tuesday, Thursday and Saturday. CNA #1 revealed that sometimes when he gets his bath and doesn't have a whole lot of facial hair growth we will wait until his next bath day to shave him. She confirmed that his facial hair was long and that it had been a while since he had been shaved. The resident stated, "Well, if y'all don't care how I look, then I guess I don't care either." An observation on 2/09/2026 at 3:05 PM, revealed Resident #111 remains unshaved, and no change in appearance from the previous observation. An observation on 2/10/2026 at 9:40 AM, revealed Resident #111 remains unshaved, and no change in	M0610		

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M0610	Continued from page 15 appearance from the previous day. During an interview on 2/10/2026 at 10:35 AM, CNA #2 revealed today is Resident #111's bath day and that is when he also gets shaved. She confirmed his facial hair was long and stated, "I really don't know when he was last shaved." During an interview on 2/10/2026 at 10:58 AM, the Director of Nursing Services (DNS) revealed it is our expectation that all residents are adequately groomed, including being shaved and presentable. During an interview on 2/10/2026 at 11:40 AM, CNA #3 stated, "I have worked with Resident #111 in the past, and I know he likes to be shaved." During an interview on 2/10/2026 at 12:00 PM, the Assistant Director of Nursing Services (ADNS) stated that the resident is to be shaved during his baths, which is a part of his personal hygiene that the facility is to honor. Record review of the Admission Record revealed Resident #111 was admitted to the facility on 2/23/2022 with diagnoses that included Spina Bifida, Psoriasis, and Need for assistance with personal care. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/02/2025 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicates Resident #111 has moderate cognitive impairment.	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 II Based on observation, resident and staff interviews,	M0615		

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M0615	Continued from page 16 record review, and facility policy review, the facility failed to ensure a resident received the necessary treatment and services to promote healing of a pressure wound for one (1) of two (2) pressure wounds reviewed. Resident #120 Findings Include: Review of the facility policy titled “Clean Dressing Change,” unrevised, revealed under “Guideline: It is the policy of this center to provide wound care in a manner to decrease the potential for infection and/or cross contamination. Physician’s orders will specify the type of dressing and frequency of changes.” Record review of Resident #120’s wound measurements dated 2/4/26 revealed a Stage 3 pressure ulcer/injury to the sacrum measuring 1.41 centimeters (cm) in length, 1.24 centimeters (cm) in width, and 0.2 centimeters (cm) in depth. An observation of Resident #120’s sacral wound care with Registered Nurse (RN) #1 on 2/9/26 at 2:20 PM revealed the resident did not have a dressing intact on the wound, and the resident was wearing an incontinence brief that was saturated with urine, with the wetness indicator line turned blue. Record review of Resident #120’s Treatment Administration Record revealed an order dated 9/5/25: “Cleanse unstageable wound to sacrum with NS (normal saline) or wound cleanser, pat dry, skin prep periwound, apply calcium alginate Ag (silver) to wound bed, and cover with foam dressing every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care.” Also revealed an order, “Cleanse unstageable wound to sacrum with NS (normal saline) or wound cleanser, pat dry, skin prep periwound, apply calcium alginate Ag (silver) to wound bed, and cover with foam dressing every 8 (eight) hours as needed if soiled or dislodged,” with no indication the dressing was replaced when this occurred for the month of February. An interview with Resident #120 on 2/9/26 at 2:31 PM revealed she had a bowel movement on Saturday night, and when staff changed her brief, they decided it would be best to remove the dressing because it was soiled. She explained that she often went without dressing when it became soiled and stated staff did not usually replace it.	M0615		

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M0615	Continued from page 17 An interview with Registered Nurse (RN) #1 on 2/9/26 at 2:34 PM confirmed Resident #120's wound did not have a dressing. She revealed the resident had a physician order to replace the dressing if it became soiled or dislodged. RN #1 stated that if a dressing was not intact, it could allow stool and urine to enter the wound and become infected. She also stated urine could cause the wound edges to become macerated and deteriorate the wound. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/25 revealed under Section M that Resident #120 had an unhealed pressure ulcer documented as unstageable due to the wound bed being covered in slough and/or eschar. Also revealed under Section H, the resident was always incontinent of urine and bowel. An interview with the Director of Nursing on 2/9/25 at 2:41 PM revealed that her expectations were for staff caring for Resident #120 to notify the nurse when the wound dressing came off or was soiled to ensure the wound received consistent treatment and healed without complications. Record review of the "Admission Record" revealed the facility admitted Resident #120 on 1/13/25 with a medical diagnosis including other complications of amputation stump and irritable bowel syndrome. Record review of the MDS with an ARD of 12/12/25 revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #120 was cognitively intact.	M0615		
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	M1570		

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M1570	Continued from page 18 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 observation, interview, record review and facility policy review the facility failed to utilize enhanced barrier precautions while providing care for two (2) of five (5) care areas observed. Resident #5 and Resident #120. Findings Include: Review of the undated facility "Infection Control Guide" revealed that "EBP refers to the expanded use of PPE (Personal Protective Equipment) and refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's (Multidrug-Resistant Organism) to staff hands and clothing.....Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO's. The use of gowns and gloves for high-contact residents is indicated when Contact Precautions do not otherwise apply, for nursing home residents with wounds/or indwelling medical devices....." An interview on 02/09/26 at 2:35 PM with Registered Nurse (RN) #1, revealed that Resident #5 had a Percutaneous Endoscopic Gastrostomy (PEG) tube that was used to administer hydration flushes and used for enteral feedings if he didn't eat a certain amount of his meals. She revealed that his PEG tube site care was ordered to be completed every day. An observation on 02/09/26 at 2:45 PM with RN #1 revealed that she performed Resident #5's PEG tube site	M1570		

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M1570	Continued from page 19 care and failed to utilize Enhanced Barrier Precautions (EBP). She donned gloves but did not wear a gown while providing the care. An interview on 02/10/26 at 2:10 PM with RN #1 revealed that she had been trained on Enhanced Barrier and that the purpose was to protect the resident from germs or bacteria she might be carrying. She also confirmed that she did not wear a gown while providing PEG tube care with Resident #5 and stated she forgot to put one on. During an interview on 02/10/26 at 2:20 PM with Infection Preventionist, she revealed that she expected the staff to utilize EBP while providing wound care and while providing care to residents with indwelling devices. She revealed that the purpose of utilizing Enhanced Barrier Precautions, was to protect the resident by preventing the staff from passing germs or bacteria to the resident which might cause infection. Record review of Resident #5's "Admission Record" revealed the most recent admission date of 10/27/25 with diagnoses that included Anoxic Brain Damage and Dysphagia. Record review of Resident #5's "Treatment Administration Record" revealed an order dated 10/27/25 to "Cleanse peg tube insertion site with NS (normal saline)/dermal wound cleanser and apply drainage sponge every day shift..." RN #1 signed that she completed the task on 02/09/26. Resident #120 Record review of Resident #120's Treatment Administration Record revealed an order dated 9/5/25: "Cleanse unstageable wound to sacrum with NS (normal saline) or wound cleanser, pat dry, skin prep peri wound, apply calcium alginate Ag (silver) to wound bed, and cover with foam dressing every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care." Record review of Resident #120's wound measurements dated 2/4/26 revealed a Stage 3 pressure ulcer/injury to the sacrum measuring 1.41 centimeters (cm) in length, 1.24 centimeters (cm) in width, and 0.2 centimeters (cm) in depth.	M1570		

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M1570	Continued from page 20 An observation of Resident #120's sacral wound care on 2/9/26 at 2:20 PM, with Registered Nurse #1 revealed she performed treatment to the wound without application of a gown for Enhanced Barrier Precautions (EBP). On 2/10/26 at 2:02 PM, an interview with Registered Nurse #1 confirmed she did not wear a gown for Resident #120's wound care. She stated the purpose of the precautions was to protect the resident from infections and explained that she had been trained on the precautions but forgot to apply the gown. During an interview with the Director of Nursing on 2/10/26 at 2:24 PM, she confirmed her expectations were for staff to practice Enhanced Barrier Precautions for the residents with chronic wounds to prevent the spread of infection. Record review of the "Admission Record" revealed the facility admitted Resident #120 on 1/13/25 with a medical diagnosis including other Complications of Amputation Stump. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #120 was cognitively intact.	M1570		