STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255284	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	3103 WISCONSIN AVENUE P O BOX 820485, VICKSBURG, Mississippi, 39180

(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 two (2) Complaint Investigations (CI MS #2740450 and CI MS #2601556), at the facility from 2/23/26 through 2/26/26. CI MS #2740450 was investigated related to call lights not answered and CI MS #2601556 was investigated related to meal menus not followed, medications not administered timely, grievance response and unaddressed nutritional concerns. There were no citations related to the complaint investigations. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and there were F558, F605, F641, F656, F802, F812, and F880 cited. The facility held a license for 60 beds, with a census of 57.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident #5's right to reasonable accommodation of her physical limitations by not maintaining a call light within reach and not providing a call light she could independently activate to request assistance, for one (1) of nineteen (19) residents sampled. Findings include: A review of the facility's policy, "Call Light/Bell" revealed, "Purpose…provide the resident a means of communication with staff members…Procedure 1. Ensure resident has call light in reach when in resident room…7. Place the call light within the resident's	F0558		

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

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F0558 SS = D	Continued from page 1 reach before leaving the room…" A record review of the "Face Sheet" revealed the facility admitted Resident #5 on 10/25/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side. A record review of the "Functional Assessment" dated 2/18/26 revealed Resident #5 had upper one-sided limitations, was dependent, and required maximal assistance with all activities of daily living (ADLs). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired. On 02/23/2026 at 1:45 PM, during an observation, Resident #5 was in bed and stated she wanted water. The call light was positioned between the bed rail and mattress, hanging near the floor and out of reach. A water pitcher was observed on the bedside stand. The resident was unable to access the call light. The Physical Therapist Assistant (PTA) retrieved the call light from between the bed rail and mattress and confirmed it had been out of the resident's reach. The resident had a dome-shaped "soft" call light and was unable to independently press the button to request assistance. On 02/25/2026 at 12:06 PM, during an observation, Resident #5 was seated upright in a chair with a splint in place on the left arm. The call light was observed on the bed and was again out of the resident's reach. On 02/25/2026 at 9:02 AM, during an interview, the Consultant and Administrator reported that after meeting with therapy staff, the facility decided to order a different type of call light to allow Resident #5 to activate a "bump" style device and added an intervention to increase rounding to every hour. On 02/25/2026 at 2:56 PM, during an interview, the Director of Nursing (DON) stated Resident #5 had a splint related to a prior stroke and confirmed a tent-style call light had been ordered because the resident was unable to activate the current device independently. On 02/26/2026 at 3:12 PM, during an interview, the Administrator stated staff were expected to follow established guidelines and ensure resident needs were	F0558		

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F0558 SS = D	Continued from page 2 met.	F0558		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F0605		

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F0605 SS = D	Continued from page 3 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F0605		

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F0605 SS = D	Continued from page 4 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident was evaluated for continued need of a PRN (as needed) psychotropic medication after fourteen (14) days for one (1) of five (5) residents reviewed for unnecessary medications, Resident #9. Findings include: A review of the facility's policy, "Psychotropic Medications," with a latest review date of 02/25, revealed, "… The facility will not use Psychotropic medications unless it is necessary to treat a specific condition as diagnosed and documented in the clinical record… PRN orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN anti-psychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication…" Resident #9 A record review of the "Face Sheet" revealed the facility admitted Resident #9 on 4/30/21 and she had diagnoses including Alzheimer's Disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #9 required a Staff Assessment for Mental Status and had short- and long-term memory problems and cognitive skills for daily decision making were severely impaired. A record review of the "Order Summary Report" with active orders as of 02/26/2026 revealed Resident #9 had a Physician's Order, dated 1/30/26, for Lorazepam Concentrate 2 milligrams (mg)/milliliter (ml), Give one	F0605		

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F0605 SS = D	Continued from page 5 (1) ml by mouth every four (4) hours as needed for Anxiety. There was no 14-day stop date indicated on the order. A record review of the facility's "GDR (Gradual Dose Reduction) List for January 2026," provided by the Director of Nursing (DON), revealed Resident #9 had lorazepam one (1) mg every four (4) hours PRN, with a notation indicating PRN anxiety medication should be limited to fourteen (14) days then reassessed. A record review of the facility's "IDT (Interdisciplinary Team) Psychotropic Dashboard February 2026," provided by the DON, revealed Resident #9 had Ativan one (1) mg every four (4) hours PRN beginning 12/12/25, with comments indicating PRN Lorazepam discontinued then reordered seven (7) days later. A record review of Resident #9's "Medication Administration Record (MAR)" for 2/1/2026 through 2/28/2026 revealed the PRN Lorazepam order initiated 01/30/2026 continued beyond fourteen (14) days without documented physician evaluation for continued need. As of 02/22/2026, the resident had received seven (7) doses after the fourteen (14) days. On 02/25/2026 at 11:10 AM, during an interview, Registered Nurse (RN) #1 reported Resident #9 had been on hospice services since December. She stated the resident had increased behaviors after Seroquel was discontinued and that Lorazepam dosage had been increased due to agitation. On 02/25/2026 at 2:20 PM, during an interview, RN #2 reported Resident #9 experienced anxiety, behaviors, and pain and had PRN orders for Lorazepam and Morphine. She stated she was unsure how often the PRN medications were administered. On 02/26/2026 at 1:00 PM, during an interview, the DON reported she was aware of the fourteen (14) day limitation for PRN anxiety medications and aware of the pharmacist recommendations. She stated she discussed the recommendation with the Hospice Nurse in January but did not follow through to ensure the medication was reassessed. She confirmed the medication should have been evaluated for continued need after fourteen (14) days. On 02/26/2026 at 3:25 PM, during an interview, the Administrator reported she expected staff to follow regulations and guidelines for psychotropic medications and was not aware the fourteen (14) day reassessment	F0605		

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F0605 SS = D	Continued from page 6 had not occurred.	F0605		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded accurately to reflect a resident's tobacco use for one (1) of nineteen (19) residents whose MDS assessments were reviewed, Resident #46. Findings include:	F0641		

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F0641 SS = D	Continued from page 7 A review of the facility's policy, "Resident Assessment," with a latest revision date of 09/19, revealed, "An assessment will be completed on each resident utilizing the MDS (Minimum Data Set) … The Registered Nurse is responsible for verifying the completion of the assessment. The completed assessment guides the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental and psychosocial well-being … Any health professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed …" A record review of the "Face Sheet" revealed the facility initially admitted Resident #46 on 6/11/25 with diagnoses including Tobacco Use. A record review of the "Smoking Screening" dated 10/21/25 revealed Resident #46 smoked or used tobacco products. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/12/25 revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated he was cognitively intact. A review of Section J1300 indicated no tobacco use. On 02/23/2026 at 1:20 PM, during an observation, Resident #46 was observed being assisted outside for a smoke break with a Certified Nurse Aide (CNA). On 02/24/2026 at 1:50 PM, during an interview, CNA #1 confirmed Resident #46 smoked daily. On 02/26/2026 at 12:05 PM, during an interview, Registered Nurse (RN) #3 confirmed she completed Resident #46's "Smoking Screening" dated 10/21/2025 and the Significant Change MDS with an ARD of 11/12/2025. She confirmed tobacco use was coded as "no" on the MDS and stated this was done in error and overlooked. She confirmed she was responsible for the accuracy of the MDS. On 02/26/2026 at 3:00 PM, during an interview, the Administrator stated she expected MDS staff to code assessments accurately to reflect the resident's care and status.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan	F0656		

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F0656 SS = D	Continued from page 8 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 §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.	F0656		

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F0656 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan intervention for one (1) of 19 sampled residents (Resident #5). Findings include: A review of the facility's policy, "Care Plan Process" (revised 12/2024) revealed, "…Regulations require facilities to complete…a comprehensive, standardized assessment of each resident's functional capacity and needs…The results of the assessment…are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care…" A record review of the "Care Plan Detail" for Resident #5 revealed a "Focus" of "The resident is Moderate risk for falls…" with an "Intervention" of "Be sure The resident's call light is within reach…" On 02/23/2026 at 1:45 PM, during an observation, Resident #5's call light was positioned between the bed rail and mattress, hanging near the floor and out of reach. The resident was unable to access the call light. On 02/25/2026 at 12:06 PM, during an observation, Resident #5's call light was on the bed and was again out of the resident's reach. On 02/25/2026 at 3:09 PM, in an interview with the Director of Nursing (DON), she stated her expectation is that staff take the time to learn each resident, understand their individual needs, and ensure those needs are consistently met. On 02/26/2026 at 3:12 PM, in an interview with the Administrator, she stated her expectation is that staff follow established guidelines, policies, and procedures for all residents to ensure safety and appropriate care. A record review of the "Face Sheet" revealed the facility admitted Resident #5 on 10/25/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side. A record review of the "Functional Assessment" dated 2/18/26 revealed Resident #5 had upper one-sided limitations, was dependent, and required maximal	F0656		

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F0656 SS = D	Continued from page 10 assistance with all activities of daily living (ADLs). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired.	F0656		
F0802 SS = D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure staff maintained competency in food safety practices by failing to properly calibrate a food thermometer prior to checking food temperatures for one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, "Calibration of Thermometers," reviewed 05/23, revealed, "Procedure: 1. All thermometers are to be calibrated: a. Before each meal…2. Ice Point Method…d. Hold the calibration nut securely with a wrench or other tool and rotate the head of the thermometer until it reads 32 degrees F (Fahrenheit)…" On 02/24/2026 at 3:37 PM, during an observation and	F0802		

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F0802 SS = D	Continued from page 11 interview with the Cook and Dietary Manager (DM), the Cook prepared to take temperature readings of food items on the steam table and calibrated the thermometer to 40 degrees Fahrenheit (F). The Cook confirmed she believed the thermometer should be calibrated to 40 degrees and stated she had been trained to do so. The Dietary Manager (DM) intervened and pointed to a posted sign instructing staff to calibrate thermometers to 32 degrees Fahrenheit (F). The Cook confirmed that an improperly calibrated thermometer could result in inaccurate temperature readings. The DM stated the Cook had been trained and in-serviced monthly and that signs were posted in the kitchen as reminders. The DM stated she expected staff to be knowledgeable about their job duties. On 02/25/2026 at 9:46 AM, during an interview, the Administrator stated she had been informed of the improper calibration by the Cook in the Dietary Department. The Administrator stated kitchen staff and management were responsible for maintaining competent food safety practices and that she expected staff to follow their training and perform their duties competently.	F0802		
F0812 SS = D	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.	F0812		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = D	Continued from page 12 This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview the facility failed to ensure sanitary food handling practices were maintained by failing to sanitize a food thermometer between checking temperatures of multiple food items on the steam table for one (1) of three (3) kitchen observations. Findings include: On 02/24/2026 at 3:37 PM, during an observation and interview, the Cook was observed standing at a two-tiered table with individual packs of cleaning wipes on the bottom shelf. The Cook retrieved a cleaning wipe and performed an initial cleaning of the thermometer. She then checked the temperature of each food item on the steam table using the same thermometer without sanitizing the thermometer wand between food items. The Cook confirmed she checked the temperature of all foods without sanitizing between items and stated it was important to keep the thermometer clean to prevent cross-contamination. During the same interview, the Dietary Manager (DM) confirmed it was the Cook's responsibility to maintain sanitary conditions on the food line. The DM stated staff received monthly in-service training, she expected proper food handling practices, and she would increase monitoring and provide reminders to staff. On 02/25/2026 at 9:46 AM, during an interview, the Administrator stated she had been informed of the kitchen practices. The Administrator stated kitchen staff and management were responsible for maintaining sanitary food handling practices. She stated she would increase monitoring in the kitchen and expected staff to consistently maintain sanitary conditions.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880		

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F0880 SS = D	Continued from page 13 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880		

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F0880 SS = D	Continued from page 14 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) as required during wound care for one (1) of two (2) wound care observations, Resident #18. Findings include: A review of the facility's policy, "Enhanced Barrier Precautions," with the latest review date of 03/24, revealed, "Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., … residents with wounds or indwelling medical devices) … Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g. Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers…" A record review of the "Face Sheet" revealed the facility admitted Resident #18 on 12/26/2025 with diagnoses including Hemiplegia and Hemiparesis. A record review of Resident #18's "Order Summary Report" with active orders as of 02/26/2026 revealed, "… Clean Stage 2 pressure ulcer to left hip with normal saline. Apply collagen to wound and cover with dry dressing, daily until healed. One time a day for Stage 2 pressure wound … order date 02/09/2026 … start date 02/10/2026 …" A record review of the Part A PPS Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/2026 revealed Section C indicated Resident #18	F0880		

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F0880 SS = D	Continued from page 15 was rarely/never understood. Section M0210 revealed the resident had one (1) or more unhealed pressure ulcers/injuries. On 02/25/2026 at 9:40 AM, during an observation and interview, wound care was performed by Registered Nurse (RN) #3 and assisted by the Director of Nursing (DON). Enhanced Barrier Precautions signage was observed above the resident's headboard and personal protective equipment (PPE) was hanging on the back of the door. During the wound care, neither RN #3 nor the DON wore a gown while providing and assisting with wound care. During the same interview following the procedure, both staff confirmed they did not wear gowns and stated they forgot to don the required PPE. On 02/25/2026 at 3:00 PM, during an interview, Licensed Practical Nurse (LPN) #1 reported that residents with pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, or indwelling catheters were placed on Enhanced Barrier Precautions with signage above the headboard and PPE stored in the room. She confirmed Resident #18 had been on Enhanced Barrier Precautions since acquiring the pressure wound and stated staff were educated on EBP and were expected to wear PPE when providing care. On 02/26/2026 at 3:23 PM, during an interview, the Administrator stated she expected all staff to follow Enhanced Barrier Precautions when providing care to residents with wounds or other conditions requiring PPE.	F0880		