STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	49 WILLOW CREEK LANE , BYRAM, Mississippi, 39272

(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 at the facility from 3/2/26 through 3/5/6. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F584, F656, F690, F761, F867 and F880. The facility was licensed for 88 beds and had a census of 77.	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 a resident's right to reasonable accommodation of communication needs when a functioning bedside telephone was not provided for one (1) of (18) sampled residents. Resident #9. Findings include: A review of the facility's policy, "Resident Rights," revised 10/24/22, revealed, "…Resident rights…The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility…" A record review of the "Face Sheet" revealed the facility admitted Resident #9 on 6/3/25 with diagnoses including Alzheimer's Disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25, revealed Resident # 9 had a Brief Interview	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 for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. On 3/2/26 at 12:37 PM, during an observation and interview, Resident #9 had a telephone sitting at the bedside which was not functioning. Resident #9's wife stated she had been attempting for approximately three months to have an incoming-call-only telephone set up at the resident's bedside because the resident had forgotten how to use his cell phone due to dementia. She stated she had spoken with the Social Worker regarding assistance with setting up the phone. She explained the Social Worker instructed her to purchase the phone and contact the phone company. The wife stated she had purchased the phone and brought it to the facility; however, she was told to contact the phone company to activate the line. She reported the phone company did not understand what was needed and stated the facility had not followed up to assist with ensuring the phone was working even though the phone remained at the resident's bedside. On 3/3/26 at 2:00 PM, during an observation and follow-up interview, the bedside telephone for Resident #9 remained in the room but was not operational. Resident #9's wife stated the bedside telephone was still not functioning. She confirmed she had previously spoken with the Social Worker about getting the phone set up but stated the issue had not been resolved and the phone remained in the resident's room without being operational. On 3/4/26 at 9:15 AM, during an observation, Resident #9 continued to have a telephone at the bedside which was not functioning. On 3/4/26 at 9:35 AM, during an interview, the Social Worker stated the typical process for setting up a landline telephone was for the resident's family to contact the phone company to establish service in the resident's room. The Social Worker stated Resident #9's wife had approached her approximately one month earlier about setting up a phone and she instructed the wife to contact the phone company. The Social Worker stated she believed the phone had been set up but acknowledged she did not follow up with the family to confirm the phone was working or to request a demonstration. On 3/4/26 at 9:49 AM, during an interview, the Maintenance Director stated the resident's family had not notified him that a phone had been brought to the facility to be installed at the resident's bedside. He stated the facility does not typically provide phones for residents and indicated he was unaware the phone	F0558		

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F0558 SS = D	Continued from page 2 needed to be set up. On 3/4/26 at 9:50 AM, during an interview, the Administrator stated it was not the facility's responsibility to follow up with the resident's family regarding the setup of the bedside phone. The Administrator stated families typically contact the phone company directly to arrange for telephone service in the resident's room. On 3/5/26 at 9:06 AM, during an interview, the Director of Nursing (DON) stated the facility should have followed up with the resident's family regarding the request for a bedside phone. The DON stated residents have the right to communicate with individuals of their choosing and acknowledged the facility failed to ensure the phone was operational for Resident #9.	F0558		
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. §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;	F0584		

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F0584 SS = D	Continued from page 3 §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, interview, record review, and facility policy review, the facility failed to ensure a resident's right to a clean, comfortable, and homelike environment when the air conditioning vent in the resident's room contained excessive dust and debris for one (1) of (18) sampled residents. Resident #9. Findings include: A review of the facility's policy, "Resident Rights," revised 10/24/22, revealed, "…Resident rights…8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment…" A record review of the "Face Sheet" revealed the facility admitted Resident #9 on 6/3/25 with diagnoses including Alzheimer's Disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25, revealed Resident # 9 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. On 3/2/26 at 12:37 PM, during an observation, the air conditioning vent in Resident #9's room contained visible dust and debris. On 3/3/26 at 1:58 PM, during an observation and interview, the air conditioning vent in Resident #9's room continued to be visibly dirty with dust and debris. Resident #9's wife stated she had notified Licensed Practical Nurse (LPN) #1 approximately one month earlier that the air conditioning vent was dusty when the resident moved into the room. She stated she	F0584		

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F0584 SS = D	Continued from page 4 was told maintenance had been notified and the vent would be cleaned, but it had not been addressed. On 3/3/26 at 4:03 PM, during an interview, LPN #1 stated she had spoken with maintenance staff approximately one month earlier about the condition of Resident #9's air conditioning vent and explained it contained dust, dried debris, and what appeared to be food particles. LPN #1 stated she did not submit a maintenance request ticket because she had spoken with maintenance staff directly. On 3/3/26 at 4:20 PM, during an interview, the Maintenance Director stated he had not received a maintenance request regarding the air conditioning vent in Resident #9's room. The Maintenance Director stated maintenance requests should be entered into the maintenance request log so the issue can be tracked and completed. The Maintenance Director reviewed the maintenance request log for D Hall and confirmed no request had been logged regarding cleaning the air conditioning vent in Resident #9's room. On 3/5/26 at 9:06 AM, during an interview, the Director of Nursing (DON) stated nursing staff should document maintenance issues using a maintenance request form or report the issue through the facility's maintenance request process to ensure repairs are completed in a timely manner.	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,	F0656		

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F0656 SS = D	Continued from page 5 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement a resident's comprehensive care plan intervention related to Enhanced Barrier Precautions for one (1) of (18) care plans reviewed. Resident #13. Findings include: A review of the facility's policy, "Care Plans," updated 2/20/20, revealed, "Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care…Procedure…Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention…" A record review of the "Care Plan Report" revealed Resident #13 had a "Focus" of "The resident has indwelling foley catheter…" with "Interventions" that	F0656		

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F0656 SS = D	Continued from page 6 included “Enhanced Barrier Precautions.” On 3/3/26 at 2:14 PM, during an observation, Certified Nursing Aide (CNA) #1 assisted by CNA #2 provided Foley catheter care to Resident #13. Staff did not wear a gown while providing catheter care despite the care plan intervention requiring Enhanced Barrier Precautions. On 3/4/26 at 2:34 PM, during an interview, CNA #2 confirmed she did not wear a gown during Resident #13’s catheter care and stated she forgot to put it on. CNA #2 stated the purple dot by the resident’s name served as a reminder that staff should wear a gown when providing care. On 3/4/26 at 2:40 PM, during an interview, CNA #1 confirmed staff did not wear a gown while providing care to Resident #13. CNA #1 stated she was responsible for ensuring Enhanced Barrier Precaution supplies were stocked outside the resident’s room and acknowledged the care plan intervention requiring a gown was not followed. On 3/4/26 at 4:15 PM, during an interview, the Director of Nursing (DON) stated staff should wear gowns when providing direct care to residents who require Enhanced Barrier Precautions and confirmed staff are expected to follow care plan interventions. On 3/4/26 at 4:33 PM, during an interview, Registered Nurse (RN) #1, the care plan nurse, stated the care plan is intended to guide staff in providing resident care and should be followed when delivering care. RN #1 explained staff are expected to follow the care plan interventions. A record review of the “Face Sheet” revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident’s cognition was severely impaired.	F0656		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident	F0690		

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F0690 SS = D	Continued from page 7 who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a Foley (indwelling catheter) was properly secured with a leg strap to prevent catheter movement and trauma for one (1) of two (2) residents reviewed for urinary catheters. Resident #13. Findings include: A review of the facility's policy, "UTI (Urinary Tract Infection) Prevention with Indwelling Catheter Use," undated, revealed, "…A resident with an indwelling catheter is susceptible to urinary tract infections…Policy Explanation…7. Catheter tubing should be secured to the resident's leg or bed clothing to prevent pulling and irritation of the urinary meatus…" On 3/3/26 at 2:14 PM, during an observation, Certified Nursing Aide (CNA) #1 assisted by CNA #2 provided Foley	F0690		

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F0690 SS = D	Continued from page 8 catheter care to Resident #13 and the catheter tubing was not secured with a leg strap. On 3/4/26 at 2:34 PM, during an interview, CNA #2 confirmed Resident #13 did not have a leg strap in place and stated she forgot to obtain one. CNA #2 stated the purpose of the leg strap was to keep the Foley catheter from being pulled out and believed it was the nurse's responsibility to ensure the leg strap was in place. On 3/4/26 at 4:15 PM, during an interview, the Director of Nursing (DON) stated the leg strap was used to keep the Foley catheter secured and maintain proper flow. The DON stated all nursing staff were responsible for ensuring a leg strap was in place and that any staff member could obtain a leg strap and secure the catheter. The DON stated the purpose of the leg strap was to prevent trauma. A record review of the "Face Sheet" revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine. A record review of the "Order Summary Report" revealed Resident #13 had a Physician's Order, dated 1/15/25, for "Urinary Catheter Care: nurse is to ensure that catheter care is provided with soap and water every shift and as needed. Leg strap secured…every shift…" A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident's cognition was severely impaired.	F0690		
F0761 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	F0761		

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F0761 SS = D	Continued from page 9 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: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were stored securely when medications were left unattended at a resident's bedside for one (1) of two (2) medication storage observations. Resident #33. Findings include: A review of the facility's policy, "Medication Storage," undated, revealed, "…Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments and biologicals must be stored securely…" On 3/3/26 at 9:00 AM, during an observation and interview, Resident #33 pointed to a medication cup sitting on the bedside table. The medication cup contained six (6) pills described as three round pills, two pink pills, and one white oblong pill. Resident #33 stated she did not know why she had to take so many medications. On 3/3/26 at 9:10 AM, during an observation, Licensed Practical Nurse (LPN) #3 entered the room and spoke with Resident #33 regarding the medications. LPN #3 stated to the resident that when she previously left the room the resident had the pills in her hands. Resident #33 stated she had told the nurse she wanted to eat first. LPN #3 then handed the medication cup to the resident, and the resident took the medications. On 3/3/26 at 9:12 AM, during an interview, LPN #3 stated she should not have left the medications in the resident's room and should have remained with the resident to ensure the medications were taken. LPN #3 stated leaving medications unattended could result in the resident discarding the medications or another	F0761		

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F0761 SS = D	Continued from page 10 resident entering the room and taking them. On 3/3/26 at 3:21 PM, during an interview, the Director of Nursing (DON) stated nurses should not leave medications at the bedside. The DON stated physician orders require medications to be administered as ordered and leaving medications unattended could allow another resident access to them. A record review of the “Face Sheet” revealed the facility admitted Resident #33 on 9/12/24 with diagnoses including Essential (Primary) Hypertension and Hyperlipidemia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/25 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. A record review of the “Order Summary Report” revealed Resident #33 had active physician orders for Ativan Oral Tablet 0.5 mg (milligrams) by mouth one time a day dated 6/2/25, Losartan Potassium Tablet 100 mg by mouth daily dated 9/12/24, Aspirin Chewable 81 mg by mouth daily dated 9/12/24, Mobic Oral Tablet 15 mg by mouth daily dated 4/2/25, Cholecalciferol Oral Tablet 2000 units by mouth daily dated 9/29/25, and Cyanocobalamin Oral Tablet 1000 units by mouth daily dated 9/29/25. A record review of the “Medication Administration Record (MAR)” revealed Licensed Practical Nurse (LPN) #3 documented Ativan, Losartan, Aspirin, Mobic, Cholecalciferol, and Cyanocobalamin as administered during the 8:00 AM medication pass on 3/3/26.	F0761		
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident	F0867		

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(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
F0867 SS = D	Continued from page 11 representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F0867		

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F0867 SS = D	Continued from page 12 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F0867		

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F0867 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to ensure proper infection control practices related to hand hygiene during Percutaneous Endoscopic Gastrostomy (PEG) tube site care during an annual recertification survey on 11/7/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F880 Findings include: A review of the facility's policy, "Quality Assurance Performance Improvement," revised 5/7/18, revealed "…Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life…" Record review of the "Provider History Profile" revealed the facility received a citation for F880 – Infection Prevention and Control that had a "Plan/Date of Correction" of 12/4/2024. Record review of the Centers for Medicare and Medicaid Services (CMS)-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 11/7/24 revealed, "…Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure proper infection controls practices were implement…for two (2) of (19) sampled residents…" During the current recertification survey, the facility failed to follow infection prevention and control practices during resident care by failing to perform hand hygiene during incontinent care (Resident #66), failing to implement Enhanced Barrier Precautions during catheter care (Resident #13), and contaminating environmental surfaces with soiled gloves during wound care (Resident #36) for three (3) of four (4) care observations. In an interview on 3/6/26, at 1:17 PM, the Director of Nursing (DON) explained that, based on current information from the State Agency (SA), the lack of	F0867		

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F0867 SS = D	Continued from page 14 hand hygiene during patient care has been a recurring issue since the last survey. The facility has not monitored this issue or implemented any performance improvement plans since the previous plan of correction, such as tracking and measuring outcomes. The DON emphasized that it is important for staff to maintain hand hygiene during care to prevent the spread of infections. At 1:30 PM on 3/6/26, in an interview with the Administrator, he revealed that he has been working at the facility since January 2026. During this time, he has been conducting Quality Assurance Performance Improvement (QAPI) meetings monthly. In those meetings, he does not recall identifying or addressing the continued tracking or monitoring of hand hygiene during resident care since the last plan of correction was implemented for the facility. However, he confirmed that this monitoring should occur, as required by their current policy.	F0867		
F0880 SS = F	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. 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:	F0880		

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F0880 SS = F	Continued from page 15 (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. §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 follow infection prevention and control practices during resident care by failing to perform hand hygiene during	F0880		

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F0880 SS = F	Continued from page 16 incontinent care (Resident #66), failing to implement Enhanced Barrier Precautions during catheter care (Resident #13), and contaminating environmental surfaces with soiled gloves during wound care (Resident #36) for three (3) of four (4) care observations. Findings include: A review of the facility's policy, "Infection Prevention and Control Program," revised 3/23/23, revealed, "…It is the policy of this facility to…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…" A review of the facility's policy, "Hand Hygiene," revised 6/12/22, revealed, "…Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection…Policy Explanation and Compliance Guidelines…1. Staff will perform hand hygiene when indicated…6. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves…Hand Hygiene Table…When, during resident care, moving from a contaminated body site to a clean body site…Either Soap and Water or Alcohol Based Hand Rub…" A review of the facility's policy, "Enhanced Barrier Precautions," revised 9/29/25, revealed, "…It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms…Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities…10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or…. discontinuation of the indwelling medical device…" Resident #66 A record review of the "Face Sheet" revealed the facility admitted Resident #66 on 3/10/21 with diagnoses including chronic kidney disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/25 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.	F0880		

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F0880 SS = F	Continued from page 17 On 3/3/26 at 9:56 AM, during an observation, Certified Nursing Aide (CNA) #3 provided incontinent care to Resident #66. CNA #3 explained the procedure to the resident and provided privacy. CNA #3 donned gloves and began peri-care without performing hand hygiene prior to initiating care. During the care, CNA #3 removed gloves and applied new gloves multiple times but did not perform hand hygiene between glove changes. CNA#3 continued peri-care, including cleaning fecal material, while changing gloves several times without performing hand hygiene. On 3/3/26 at 10:29 AM, during an interview, CNA #3 confirmed she did not perform hand hygiene between glove changes during Resident #66's care. CNA #3 stated she washed her hands after completing care but acknowledged she should have performed hand hygiene when removing gloves and before donning clean gloves. On 3/3/26 at 3:21 PM, during an interview, the Director of Nursing (DON) stated staff should perform hand hygiene upon entering the resident room and each time gloves are removed during care. The DON stated hand hygiene is required to prevent the spread of infection between residents and environmental surfaces. Resident #13 A record review of the "Face Sheet" revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine. A record review of the "Order Summary Report" revealed Resident #13 had a physician order dated 1/15/25 for urinary catheter care which instructed staff to provide catheter care with soap and water every shift and as needed. A record review of the Quarterly MDS with an ARD of 2/2/26 revealed Resident #13 had a BIMS score of six (6), which indicated the resident's cognition was severely impaired. On 3/3/26 at 2:14 PM, during an observation, CNA #1 assisted by CNA #2 provided Foley (indwelling catheter) care to Resident #13. CNA #1 gathered supplies, entered the room, explained the procedure, performed hand hygiene, and applied clean gloves. During the catheter care observation, the staff did not don a gown while providing care to a resident with an indwelling urinary catheter. On 3/4/26 at 2:34 PM, during an interview, CNA #2	F0880		

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F0880 SS = F	Continued from page 18 confirmed she did not put on a gown prior to providing catheter care. CNA #2 stated the purple dot next to the resident's name served as a reminder that staff should wear a gown when providing care and acknowledged she forgot to don the gown. On 3/4/26 at 2:40 PM, during an interview, CNA #1 confirmed staff did not wear a gown while providing catheter care to Resident #13. CNA #1 stated gowns should be worn during care to reduce the risk of spreading infection between residents. On 3/4/26 at 4:15 PM, during an interview, the DON stated staff should wear gowns when providing direct care to residents who require Enhanced Barrier Precautions. The DON stated the purpose of Enhanced Barrier Precautions is to reduce the spread of infection between residents and staff. Resident #36 A record review of the "Face Sheet" revealed the facility admitted Resident #36 on 11/10/17 with diagnoses including Dementia. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/26 revealed Resident #36 required a staff assessment for mental status and had long-term memory impairment. A record review of the "Order Summary Report" revealed Resident #36 had a physician order dated 2/11/26 for wound care to a pressure ulcer on the left great toe. On 3/4/26 at 12:16 PM, during an observation, Licensed Practical Nurse (LPN) #4 performed wound care to Resident #36's pressure ulcer on the left great toe. During the procedure, while wearing the same gloves used during wound care, LPN #4 picked up a dressing from the floor to discard and then used the same gloves to touch the bed remote control to lower the bed. On 3/4/26 at 12:21 PM, during an interview, LPN #4 confirmed she touched the wound site, the floor, and the bed remote control while wearing the same gloves. LPN #4 acknowledged she should have removed her gloves and performed hand hygiene before touching environmental surfaces in the room. On 3/5/26 at 9:59 AM, during an interview, the DON stated staff should remove contaminated gloves and perform hand hygiene before touching other surfaces during resident care. The DON stated failure to follow infection control practices could result in	F0880		

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F0880 SS = F	Continued from page 19 contamination of environmental surfaces and the spread of infection.	F0880		