STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	**1730 DORCHESTER DR , SOUTHAVEN, Mississippi, 38671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with three (3) Complaint Investigations (CI MS #2976515, CI MS #2982050, and CI MS #2982780) at the facility from 4/20/2026 through 4/23/2026. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F550, F558, F584, F656, F658, F677, F693, F695, F697, and F880. The SA identified non-compliance and cited F880 for infection control for CI MS #2982050. The SA investigated CI MS #2976515 and CI MS #2982780 with no deficiencies cited. The facility had a census of 130 and was licensed for 140 beds.	F0000		
F0656 SS = G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide	F0656		

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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F0656 SS = G	Continued from page 1 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, resident and staff interviews, record review, and facility policy review, the facility failed to ensure the Activities of Daily Living (ADL) care plan was implemented for personal hygiene and grooming (Resident #101 and Resident #119) and failed to implement a pain care plan (Resident #144) for three (3) of 31 care plans reviewed. Resident #101, #119, and #144. Findings Include: Record review of the facility policy titled “Care Plans” revealed under, “Guideline: Care plans will be developed for all patients and residents based upon the RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change.” Resident #101 Record review of Resident #101’s Activity of Daily Living (ADL) care plan revealed, "Self-care performance deficit related to Hemiplegia....Provide	F0656		

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F0656 SS = G	Continued from page 2 bathing/showering: provide hair care, shave facial hair daily on bath days and as necessary." During an observation on 4/20/2026 at 10:55 AM, Resident #101 was observed in his room with approximately 1/4-1/2-inch facial hair and long hair extending to the top of his shoulders. During interview, Resident #101 stated he wanted bath and to be shaved and have his hair cut. He reported the aide assisting him does not shave or cut hair. Resident #101 stated he did not want his hair to be that long and reported it "looks like a woman's hair." He further stated he had to be placed on a list for a haircut; however, he is bedbound and unable to speak with staff regarding placement on the list. During an interview on 4/22/2026 at 12:23 PM, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed it is the expectation for residents to be bathed on their scheduled bath days and to have their hair washed. On 4/22/2026 at 3:00 PM, interview with the Minimum Data Set (MDS) Coordinator #1 confirmed Resident #101 required assistance with bathing and shaving. The MDS Coordinator stated the resident's care plan directs staff on how to properly care for the resident and meet individualized needs. The MDS Coordinator further confirmed the care plan was not implemented if the resident was not bathed and his hair was not shampooed. The resident's scheduled bath days were Tuesdays, Thursdays, and Saturdays. Record review of Resident #101 “Admission Record” revealed the resident was admitted 3/15/2024 with a medical diagnosis that includes Hemiplegia. Record review of Resident #101 Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 3/21/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #101 is cognitively intact. Resident #119 Record review of Resident #119’s Activity of Daily Living (ADL) care plan revealed, "Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated. Revised 11/10/2025…”	F0656		

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F0656 SS = G	Continued from page 3 On 4/20/2026 at 10:29 AM during an observation and interview, Resident #119 was observed with visibly oily hair. The resident stated she received two (2) baths the previous week; however, she reported it had been approximately three (3) weeks prior to that and another three (3) weeks before that between baths. On 4/22/2026 at 10:00 AM, during an interview the ADON confirmed Resident #119 is cognitively intact. She stated, “We try to accommodate the residents as best we can.” She further stated residents should receive showers three (3) times per week unless they decline. During an interview on 4/22/2026 at 3:07 PM with the Registered Nurse Assessment Coordinator (RNAC) and the MDS Coordinator, the RNAC reviewed Resident #119’s ADL care plan and confirmed that it did not specify the frequency or schedule for showers. The MDS Coordinator stated baths and showers are provided according to a shower schedule located at the nursing station and explained the schedule is organized by room number rather than by resident, as room changes could affect the schedule. She stated that when a Certified Nursing Assistant (CNA) provides a bath or shower, the CNA completes a “CNA Bath & Shower Report” and submits it to the nurse. The nurse is responsible for verifying the resident received the bath or shower and signing the form, and if the resident refuses, the CNA reports the refusal to the nurse, who then verifies the refusal with the resident and signs the form. Further interview with the RNAC revealed the task frequency for bathing and showering was documented as “every shift.” The RNAC stated the care plan was not being followed by nursing staff and needed to be reviewed and revised to reflect an accurate bathing schedule. Review of the "Admission Record" indicated that the facility admitted Resident #119 on 8/16/2024 with medical diagnoses that included Paraplegia, unspecified. A record review of the MDS with an ARD of 2/10/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #119 was cognitively intact. Resident #144 Record review of Resident #144’s “Care Plan Report” revealed under, “Focus: Resident has pain	F0656		

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F0656 SS = G	Continued from page 4 related to lymphedema." Also revealed under, "Interventions: Administer analgesia per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain." During an observation and interview with Resident #144 on 4/20/26 at 11:15 AM, she was lying in bed with facial frowning and rubbing her right knee, which had gross edema and was propped up on a pillow. The resident stated she was hurting in her right knee down to her foat, which she described as "aching and throbbing," and verbalized her pain score as a level 10 (ten) on a pain scale from 0 (zero) to 10, with 10 being the most severe. The resident stated she had been asking for pain medication since 8:00 AM that morning, pushing the call light multiple times, and stated, "They come in here and tell me they will have to tell the nurse, and no one ever comes back." The resident revealed she was unable to eat breakfast because she was hurting so badly. At the time of observation, Resident #144 had not received pain medication despite requesting it since approximately 8:00 AM. On 4/20/26 at 11:20 AM An interview with Certified Nurse Aide (CNA) #1 revealed she had responded to Resident #144's call light twice that morning and confirmed she notified Registered Nurse (RN) #1 on both occasions that the resident requested pain medication. On 4/20/26 at 11:22 AM an interview with RN #1 revealed she came on shift at 8:45 AM. She stated that the Nurse Practitioner (NP) had told her approximately 30 minutes earlier that Resident #144 needed pain medication; however, she had not yet administered it. RN #1 stated that no one other than the NP had reported to her that the resident needed pain medication. On 4/20/26 at 11:25 AM, during an observation RN #1 assessed Resident #144's pain. The resident reported a pain score of 10 to her right knee and leg. Despite CNA #1 reporting the resident's pain to RN #1 on two occasions, RN #1 reported she had not been notified, indicating a breakdown in communication and failure to follow the resident's care plan. Record review of Resident #144's "Medication Administration Record (MAR)" revealed orders dated 4/13/26, "Tylenol (pain) 325 MG (milligrams) take 2 (two) tablet by mouth every 4 (four) hours as needed for mild pain (1-3); Tramadol (pain) HCL (hydrochloride) oral tablet 50 MG (milligrams) give 1 (one) tablet by mouth every 6 (six) hours as needed	F0656		

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F0656 SS = G	Continued from page 5 for pain related to lymphedema, pain unspecified." Further review revealed the most recent administration time for Tramadol was on 4/19/26 at 8:28 AM and Tylenol was last administered on 4/18/26 at 2219 (10:19 PM). An interview with RN #1 on 4/22/26 at 11:55 AM confirmed Resident #144's pain care plan was not followed as medication was not administered timely. An interview with the DON on 4/22/26 at 2:48 PM revealed the purpose of the care plan was to ensure that staff knew what care to provide for the residents. She confirmed that Resident #144's pain care plan was not followed. Record review of the "Admission Record" revealed the facility admitted Resident #144 on 4/10/26 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Distal Lower Extremity, Lymphedema, and Pain. Record review of the MDS with an ARD of 4/16/26 revealed under Section C, a BIMS summary score of 13, which indicated Resident #144 was cognitively intact.	F0656		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure timely assessment and management of pain for one (1) of 16 residents residing on the rehabilitation unit (Resident #144), resulting in a delay of greater than three hours in treatment, prolonged unrelieved pain at a level ten (10), inability to eat, and unnecessary physical suffering. Findings include: Review of the facility policy titled "Pain Management" revealed under, "Purpose: To provide guidelines for consistent evaluation, management and documentation of pain in order to provide	F0697		

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F0697 SS = G	Continued from page 6 maximum comfort and enhanced quality of life..." An observation and interview with Resident #144 on 4/20/26 at 11:15 AM revealed she was lying in bed with facial frowning and rubbing her right knee, which had gross edema and was propped up on a pillow. The resident stated she was hurting in her right knee down to her foot, which she described as "aching and throbbing," and verbalized her pain score as a level 10 (ten) on a pain scale from 0 (zero) to 10, with 10 being the most severe. The resident stated she had been asking for pain medication since 8:00 AM that morning, pushing the call light multiple times, and stated, "They come in here and tell me they will have to tell the nurse, and no one ever comes back." The resident revealed she was unable to eat breakfast because she was hurting so badly. An interview with Certified Nurse Aide (CNA) #1 on 4/20/26 at 11:20 AM revealed she had responded to Resident #144's call light twice that morning since her shift began at 7:00 AM. She explained that the resident reported pain and requested pain medication both times and stated she notified Registered Nurse (RN) #1, who was working the medication cart. CNA #1 confirmed the resident did not eat breakfast and stated the resident verbalized she could not eat due to pain. An interview with RN #1 on 4/20/26 at 11:22 AM revealed she came on shift at 8:45 AM. She stated that the Nurse Practitioner (NP) had told her approximately 30 minutes earlier that Resident #144 needed pain medication; however, she had not yet administered it. RN #1 stated that no one other than the NP had reported to her that the resident needed pain medication. She revealed the resident had Tylenol and Tramadol as needed for pain. During an observation on 4/20/26 at 11:25 AM, RN #1 assessed Resident #144's pain. The resident reported a pain score of 10 to her right knee and leg. Despite CNA #1 reporting the resident's pain to RN #1 on two occasions, RN #1 reported she had not been notified, indicating a breakdown in communication and failure to act upon reported pain. At the time of observation, Resident #144 had not received pain medication despite requesting it since approximately 8:00 AM. Record review of Resident #144's "Medication Administration Record (MAR)" revealed an order dated 4/13/26, "Monitor for pain every shift. Pain scale 0-10. Notify physician for unrelieved pain. Observe for nonverbal s/s (signs/symptoms) of pain	F0697		

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F0697 SS = G	Continued from page 7 every shift for pain monitoring." The resident's pain scale on 4/20/26 was documented as 10. Record review of Resident #144's "MAR" revealed orders dated 4/13/26, "Tylenol (pain) 325 MG (milligrams) take 2 (two) tablet by mouth every 4 (four) hours as needed for mild pain (1-3); Tramadol (pain) HCL (hydrochloride) oral tablet 50 MG (milligrams) give 1 (one) tablet by mouth every 6 (six) hours as needed for pain related to lymphedema, pain unspecified." Further review revealed the most recent administration time for Tramadol was on 4/19/26 at 8:28 AM with a documented pain scale of 10. Tylenol was last administered on 4/18/26 at 2219 (10:19 PM) with a documented pain score of 4. An interview on 4/20/26 at 11:40 AM with the NP revealed Resident #144 has a deep vein thrombosis (blood clot) in her right leg. She revealed she visited the resident this morning and the resident reported pain. The NP stated she reported to RN #1 that the resident needed pain medication. She explained that Tramadol was effective for the resident's pain management and acknowledged it should be administered timely for optimal pain control. Record review of Resident #144's "Progress Notes" dated 4/20/26 revealed the resident was visited by the NP with the following documented entry, "Resident complains of right lower extremity pain rated 10 out of 10 at time of complaint." An interview with the Occupational Therapist (OT) on 4/22/26 at 11:20 AM revealed Resident #144 was at the facility for rehabilitation and was on the OT caseload. He revealed the resident reports pain daily and that he notifies the nurse on duty. Record review of Resident #144's "Occupational Therapy Treatment Encounter Notes" dated 4/14/26 revealed under, "Pain: Pain level determined based upon behaviors exhibited by patient; Behaviors Exhibited: yelling, wincing, grimacing; Does pain limit patient's functional activities? Yes; Pain limits the following functional activities: bed mobility, rolling, scooting, standing, etc.. (etcetera)." An interview with RN #1 on 4/22/26 at 11:55 AM confirmed Resident #144's pain medication was not administered timely, acknowledging this caused the resident unnecessary discomfort. An interview with the Director of Nursing (DON) on 4/22/26 at 2:48 PM confirmed that Resident #144 not receiving pain medication timely was a "big concern." She stated that her expectation was that if	F0697		

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F0697 SS = G	Continued from page 8 a resident was on the call light requesting pain medication, the nurse should stop and administer it. The DON stated, "As soon as you're aware of it, it's your priority." Record review of the “Admission Record” revealed the facility admitted Resident #144 on 4/10/26 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Distal Lower Extremity, Lymphedema, and Pain. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/16/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #144 was cognitively intact.	F0697		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F0550		

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F0550 SS = D	Continued from page 9 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident interviews, staff interviews, record review, and facility policy review, the facility failed to ensure residents were treated with dignity and respect by maintaining privacy and providing personal care in a manner that preserved resident dignity for four (4) of 31 residents reviewed (Residents #20, #101, #111, #119). Findings Include: Review of facility policy, "Resident Rights & Quality of Life Policy" with an effective date of March 13, 2020, revealed, "...all patients and residents have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center..." Resident #20 On 4/20/2026 at 10:32 AM, Resident #20 was observed in his room with a urinary catheter bag containing yellow urine. The resident's room door was open, and the catheter bag was visible from the hallway, with no privacy cover in place. During an interview, Resident #20 stated he had returned from the hospital approximately one week prior and reported that no privacy bag had been placed over the catheter bag. A second observation was made on 4/21/2026 at 3:00 PM, observed catheter bag from the doorway with yellow urine visible. Upon entering the room, approximately 600 milliliters (mL) of yellow urine was observed in the catheter bag, which remained uncovered. On 4/21/2026 at 3:35 PM, interview with Licensed Practical Nurse (LPN) #1, revealed the catheter bag should have had a privacy bag in place for dignity.	F0550		

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F0550 SS = D	Continued from page 10 During an interview on 4/22/2026 at 12:20 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed it is the facility's expectation for all catheter bags to have a privacy cover in place. Record review of the "Admission Record" revealed that the facility admitted Resident #20 on 8/27/2024 with a medical diagnosis that included Paraplegia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/2026 revealed under section C, a Brief Interview for Mental Status BIMS summary score of 15, which indicated Resident #20 was cognitively intact. Resident #101 On 4/20/2026 at 10:55 AM, Resident #101 was observed in his room with approximately 1/4-inch to 1/2-inch facial hair and long hair extending to the top of his shoulders. During the interview, Resident #101 stated he wanted to be shaved and his hair cut. He reported the aide who assisted him does not shave or cut hair. The resident stated he did not want his hair to be that long and reported it "looks like a woman's hair." He further stated he was told there is a list he must be placed on to receive a haircut; however, he is bedbound and unable to go speak with staff about being placed on the list. The resident stated he had asked several aides about it, but they did not provide an answer. On 4/22/26 at 9:00 AM, the Assistant Director of Nursing (ADON) confirmed the resident's hair was long and that the resident had previously requested a haircut. Record review of Resident #101 “Admission Record” revealed the resident was admitted 3/15/2024 with a medical diagnosis that included Hemiplegia. Record review of Resident #101 MDS, Section C, with an ARD of 3/21/2026, revealed a BIMS score of 15, indicating Resident #101 is cognitively intact. Resident #111	F0550		

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F0550 SS = D	Continued from page 11 On 4/20/2026 at 10:15 AM, Resident #111 was sitting in the dayroom/dining area on the East/West halls along with other residents and staff. It was observed that an unidentified staff member was shaving her face in the common area with other residents present. During an interview with Resident #111 on 4/20/2026 at 10:30 AM, she stated someone did shave her face, but couldn't remember the staff member's name. During an interview on 4/22/2026 at 9:53 AM with the Director of Nursing (DON), she stated that no resident should ever be shaved in the common area/dining area. It is not the expectation of the facility to provide care in that manner. Record review of Resident #111 “Admission Record” revealed the resident was admitted 9/05/2024 with medical diagnosis that included Cognitive Communication Deficit. Record review of Resident #111 MDS, Section C, with an ARD of 3/11/2026, revealed a BIMS score of 6, indicating Resident #111 had severe cognitive impairment. Resident #119 During an observation on 4/20/2026 at 10:29 AM, Resident #119’s catheter bag was hanging on the bedside with no privacy cover, and the bag was filled with urine and was visible from the doorway. During an interview on 4/21/2026 at 3:40 PM, LPN #6 stated that privacy bags should always be placed on catheter bags to protect the dignity of the residents. Record review of the "Admission Record" indicated that the facility admitted Resident #119 on 8/16/2024 with medical diagnoses that included Paraplegia, unspecified. A record review of the MDS with an ARD of 2/10/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #119 was cognitively intact.	F0550		

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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, resident and staff interview, record review, and facility policy review, the facility failed to reasonably accommodate resident needs by not ensuring the call light was accessible (Resident #54) and by failing to timely address and replace an uncomfortable mattress (Resident #42) for two (2) of four (4) residents reviewed for accommodation of needs and preferences. Findings Include: Review of the facility policy titled “Resident Rights & (and) Quality of Life Policy” revealed under, “Procedure: A patient or resident has the right: … To receive services in a center environment that is safe, clean, and comfortable”. Review of facility policy titled "Nurse Call System" with effective date: 9/1/2014, revealed, "...2. Each cord needs to be visible and reachable by the resident to which it operates for... Resident #42 An observation of Resident #42 on 4/20/26 at 11:45 AM revealed he was sitting in his wheelchair in his room. The resident stated his mattress was uncomfortable, dipped in the middle, and felt like a rod was poking him. He further stated he had asked multiple staff members, including Maintenance, to replace the mattress; however, it had not been replaced. Observation of the mattress revealed two pillows placed vertically across the mattress. The resident reported he slept on top of the pillows for additional support and cushioning, stating this issue had impacted his sleep. An interview with Maintenance on 4/20/26 at 4:24 PM confirmed he was aware Resident #42 had reported his mattress as uncomfortable a couple of weeks prior. Maintenance stated the mattress was not replaced at that time because the facility needed to order new mattresses. He acknowledged that the residents' comfort was of the utmost importance, as it affected his comfort and sleep.	F0558		

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F0558 SS = D	Continued from page 13 An interview with the Director of Nursing (DON) on 4/22/26 at 3:09 PM revealed Resident #42 should have a bed that was comfortable and confirmed that the mattress had not been replaced. Record review of the “Admission record” revealed the facility admitted Resident #42 on 3/25/26 with a medical diagnosis that included Chronic Diastolic (Congestive) Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/18/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #42 was moderately cognitively impaired. Resident #54 During an observation and interview on 4/20/2026 at 10:54 AM, Resident #54 was observed to be visibly uncomfortable, holding her stomach and stating she needed to use the bathroom and needed a bedpan. Resident #54’s call light was observed wrapped around the grab bar attached to the bed, hanging down toward the floor, and was not within the resident’s reach. During an observation and interview on 4/20/2026 at 10:56 AM, the Assistant Director of Nursing (ADON) confirmed the call light was wrapped around the grab bar. She unwrapped the cord and placed the call light within reach of the resident. She stated the call light should always be within the resident’s reach, especially when the resident is in bed, and that the call light is the resident’s means of communicating her needs. Record review of the "Admission Record" indicated that the facility admitted Resident #54 on 2/24/2026 with medical diagnoses that included Chronic Diastolic (Congestive) Heart Failure, Pressure Ulcer of sacral region, stage 4, Osteomyelitis, unspecified, Unspecified severe protein-calorie malnutrition, Dysphagia, oropharyngeal phase, Other symptoms and signs concerning food and fluid intake. A record review of the MDS with an ARD of 4/15/26 revealed under section C, a BIMS summary score of 3 which indicated Resident #54 was severely cognitively impaired.	F0558		

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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; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility	F0584		

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F0584 SS = D	Continued from page 15 failed to maintain a shower room in a safe manner to prevent potential hazards to residents and staff as evidenced by an obstructed floor drain resulting in water accumulation and flooding, for one (1) of three (3) shower rooms observed. East wing Findings Include: Review of the facility policy titled “Resident Rights & (and) Quality of Life Policy” revealed under, “Procedure: A patient or resident had the right: … To receive services in a center environment that is safe, clean, and comfortable”. An interview with Resident #138 on 4/21/26 at 3:01 PM revealed she received a shower the previous night on E hall. She stated the shower room drain was stopped up, causing water to stand on the floor. The resident reported the water accumulated to the point that she was afraid she might fall. She further revealed on a previous night , she witnessed water overflowing out of the shower room into the hallway and in front of the nurse’s station, at which time staff placed towels on the floor to absorb the overflow. An interview with Licensed Practical Nurse (LPN) #1 on 4/21/26 at 3:08 PM revealed she had observed water overflow into the hallway from the east shower room on multiple occasions and confirmed she had not reported the issue to anyone. An observation and interview with Maintenance on 4/21/26 at 3:15 PM revealed the facility utilized TELS (electronic work order repair system) for staff to report maintenance concerns. During observation, after running the right shower stall for approximately five minutes, water was noted to accumulate on the floor and failed to drain. Maintenance confirmed the drain was backed up and acknowledged this condition could create a slip and fall risk for residents and staff. Maintenance further denied prior awareness of the issue. An interview with Resident #57 on 4/21/26 at 4:43 PM revealed the clogged shower drain had been an ongoing issue for several months. The resident stated he had continued to shower despite the drain being clogged and reported that even when staff attempted to unclog it, the drain would clog up again the following day. He further stated the shower room had flooded on several occasions. An interview with the Director of Nursing (DON) on 4/22/26 at 3:09 PM revealed that a couple of weeks prior, the facility had to call an outside company to	F0584		

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F0584 SS = D	Continued from page 16 assess the problem with the shower drain due to flooding in the shower room. She acknowledged that pooling water on the floor presents a safety risk to both residents and staff. Record review of the “Admission Record” revealed the facility admitted Resident #57 on 7/12/25 with medical diagnoses that included Hereditary and Idiopathic Neuropathy, Muscle Weakness, and Repeated Falls. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #57 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #138 on 11/14/25 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Repeated Falls. Record review of the MDS with an ARD of 2/20/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #138 was cognitively intact.	F0584		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure nursing services were provided in accordance with professional standards of practice and physician orders for one (1) of seven (7) resident care observations (Resident #5). Findings Include: Review of the facility's "Standards of Practice" typed on letterhead revealed, "The expectation set forth by (Proper Name) management is that nurses comply with current standards of practice by following physician orders for providing to peg site care." An observation on 04/21/26 at 2:55 PM of Resident #5's Percutaneous Endoscopic Gastrostomy (PEG)	F0658		

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F0658 SS = D	Continued from page 17 tube site revealed no dressing in place and there was a yellowish-brown substance beneath the external skin disk and extended out about one-fourth of an inch to surrounding skin. An observation and interview on 04/21/26 at 3:00 PM in Resident #5's room, revealed Licensed Practical Nurse (LPN) #5, enter and she stated that she came in to change Resident #5's PEG tube site dressing. She stated she didn't know what the orders were on Resident #5's Medication Administration Record (MAR) and LPN #5 proceeded with the care. An observation revealed that LPN #5 cleaned Resident #5's PEG tube site with an adult cleansing cloth, she patted it dry and applied a dressing. LPN #5 confirmed that there was no dressing intact to Resident #5's PEG tube site when she assessed the site prior to performing care. An interview on 04/22/26 at 8:27 AM with LPN #5, revealed that sometimes she used soap and water and sometimes she used the "wipes" (adult cleansing cloths) to clean the dried drainage surrounding the PEG site depending on where it was on the skin. LPN #5 reviewed the physician orders and confirmed that the order on Resident #5's MAR was to clean the peg tube site with normal saline, pat dry, and apply a dry drain dressing to avoid skin breakdown. LPN #5 revealed that it was nearing the end of her shift yesterday when observed, and she did not follow the physician orders. She also confirmed that by not following the physician orders, she could have caused skin irritation. An interview on 04/22/26 at 10:27 AM with Assistant Director of Nursing (ADON), revealed that her expectation was for nurses to follow the physician orders when providing resident care. She revealed that PEG tube sites should be cleaned every day and should be cleaned with soap and water or normal saline, and if there was an order for a dressing to be applied, it should be done. She revealed that by cleaning Resident #5's PEG tube site with an adult wipe, she could have caused skin irritation or burning. She also revealed that this was unacceptable practice. An interview on 04/22/26 at 10:33 AM with Registered Nurse (RN) #1, Infection Preventionist, revealed that they expected nurses to assess PEG tube sites daily and clean around the stomas with soap and water or normal saline. She revealed that she also expected nurses to review physician orders and provide the care accordingly. RN #1 revealed that failure to clean the PEG tube sites as ordered could result in skin irritation, burning of the skin, or infection. Record review of Resident #5's "Admission Record" revealed an original admission date of 08/07/20 and that she had diagnoses that included Alzheimer's Disease, Unspecified, Functional Quadriplegia, and Gastrostomy Status. Record review of Resident #5's	F0658		

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F0658 SS = D	Continued from page 18 "Medication Administration Record" with order date of 09/10/2025, revealed "Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin breakdown." Record review of Resident #5's "Order Summary Report" revealed an order with effective date of 09/10/25 documented, "Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin breakdown."	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure assistance with activities of daily living (ADLs), including bathing and personal hygiene, was provided in accordance with resident needs and preferences for two (2) of thirty-one (31) residents sampled. (Residents #101 and #119) Findings include: Review of facility policy titled Activities of Daily Living (ADL's) with effective date August 2021, revealed, "Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences..." Resident #101 On 4/20/2026 at 10:55 AM, Resident #101 was observed in his room with approximately 1/4-1/2-inch facial hair and oily long hair extending to the top of his shoulders. Interview with the resident stated he had not had a bath for more than one week and he couldn't remember how long it had been since his hair was shampooed or cut. On 4/22/2026 at 12:23 PM, interviews with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed it is the expectation for residents to be bathed on their scheduled bath days and to have their hair washed.	F0677		

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F0677 SS = D	Continued from page 19 Record review of Resident #101 “Admission Record” revealed the resident was admitted 3/15/2024 with a medical diagnosis that includes Hemiplegia. Record review of Resident #101 Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 3/21/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #101 is cognitively intact. Resident #119 During an observation and interview on 4/20/2026 at 10:29 AM, Resident #119 was observed with visibly oily hair. The resident stated she received two (2) baths the previous week; however, she reported it had been approximately three (3) weeks prior to that and another three (3) weeks before that between baths. During an interview on 4/22/2026 at 10:00 AM, the ADON confirmed Resident #119 is cognitively intact. She stated, “We try to accommodate the residents as best we can.” She further stated residents should receive showers 3 times per week unless they decline. Record review of the "Admission Record" indicated that the facility admitted Resident #119 on 8/16/2024 with medical diagnoses that included Paraplegia, unspecified. A record review of the MDS with an ARD of 2/10/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #119 was cognitively intact.	F0677		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F0693		

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F0693 SS = D	Continued from page 20 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure percutaneous endoscopic gastrostomy (PEG) feedings were administered in a manner to prevent complications for two (2) of five (5) PEG feedings observed. (Residents #54 and #121) Findings include: Review of facility Performance Checklist Skill 31-4 Administering Enteral Nutrition: Nasoenteric, Gastrostomy or Jejunostomy Tube with no date revealed, "…labeled bag properly…" During an observation on 4/20/2026 at 10:54 AM, Resident #54's tube feeding bottle of Jevity 1.5 was observed without proper labeling, including date, time, and nurse initials. During an observation on 4/20/2026 at 11:01 AM, Resident #121's tube feeding bottle of Jevity 1.5 was observed without proper labeling, including date, time, and nurse initials. During an interview on 4/20/2026 at 11:05 AM, the Assistant Director of Nursing (ADON) confirmed the feeding bottles were not dated, timed, or initialed by nursing staff. She stated, "This should be done every time a new bottle of feeding is hung. Now we have no way of knowing how long these bottles have been running." Record review of the "Admission Record" indicated that the facility admitted Resident #54 on 2/24/2026 with medical diagnoses that included Chronic Diastolic (Congestive) Heart Failure, Pressure Ulcer of sacral region, stage 4, Osteomyelitis, unspecified, Unspecified severe protein-calorie malnutrition, Dysphagia, oropharyngeal phase, Other symptoms and signs concerning food and fluid intake.	F0693		

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F0693 SS = D	Continued from page 21 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3 which indicated Resident #54 was severely cognitively impaired. Record review of the "Admission Record" indicated that the facility admitted Resident #121 on 2/12/2024 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side. A record review of the MDS with an ARD of 1/31/26 for Resident #121 revealed under section C, a BIMS should not be conducted because the resident is rarely or never understood.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to ensure physician-ordered oxygen therapy for one (1) of four (4) residents requiring oxygen. Resident #145 Findings Include: Review of the facility policy titled “Oxygen Guideline” revealed under, “Policy: Medical oxygen is classified by the Food and Drug Administration as a drug; therefore, it is provided in accordance with a health care provider’s order and in accordance with acceptable standards of practice...” On 4/21/2026 at 8:30 AM, observation of Resident #145 revealed the resident was sitting in a wheelchair in her room with an oxygen nasal cannula in place, with the concentrator set at two (2) liters.	F0695		

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F0695 SS = D	Continued from page 22 Record review of the “Clinical Health Status Evaluation” dated 4/14/26 revealed Resident #145 was on continuous oxygen. Record review of Resident #145’s “Order Listing” revealed no physician order for oxygen. An interview on 4/22/2026 at 11:08 AM with Licensed Practical Nurse (LPN) #4 revealed Resident #145 was on continuous oxygen at 2 liters per minute for Chronic Obstructive Pulmonary Disease (COPD). LPN #4 confirmed the resident did not have a physician order for oxygen and stated that an order should have been in place. On 4/22/2026 at 2:48 PM, an interview with the Director of Nursing (DON) confirmed there should be a physician order for oxygen. She revealed the nurse admitting the resident was responsible for ensuring an order was in place. Review of the “Admission Record” revealed the facility admitted Resident #145 on 4/14/2026 with a medical diagnosis of Chronic Obstructive Pulmonary Disease, Unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #145 was severely cognitively impaired.	F0695		
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. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880		

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F0880 SS = D	Continued from page 23 §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. §483.80(e) Linens. Personnel must handle, store, process, and transport	F0880		

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F0880 SS = D	Continued from page 24 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, resident and staff interview, record review, and facility policy review, the facility failed to implement infection control practices to prevent the spread of infection by not maintaining aseptic technique and not providing dressing changes during 3 (three) of 7 (seven) care area observations. Resident #5, Resident #23, Resident #54. Findings Include: Review of the facility policy, "Infection Control" with effective date of 11/01/2017 revealed, "This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections..." Review of the facility policy titled “Clean Dressing Change,” dated February 2026, revealed, “It is the policy of this center to provide wound care in a manner to decrease potential for infection and/or cross-contamination…9. Loosen the tape and remove the existing dressing…10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves…” Review of the facility Peri-Care Audit Tool, undated, revealed, “…Removes soiled brief, washes front to back, changes side of cloth or disposable wipe with each swipe… STOP! Removes gloves, washes/sanitizes hands and re-gloves…” RESIDENT #5 An observation on 04/21/2026 at 2:55 PM revealed Resident #5’s Percutaneous Endoscopic Gastrostomy (PEG) tube site with no dressing in place and there was a yellowish-brown substance beneath and surrounding the external skin disk and extending approximately one-fourth inch to surrounding skin. Certified Nursing Assistant (CNA)	F0880		

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F0880 SS = D	Continued from page 25 #2 was present in Resident #5's room and confirmed the absence of a dressing, she confirmed the yellowish-brown substance and stated her PEG tube site looked like this often. At 3:00 PM, Licensed Practical Nurse (LPN) #5 entered Resident #5's room and confirmed that there was no dressing in place to Resident #5's PEG tube site and confirmed the presence of yellowish-brown drainage to the site. LPN #5 revealed that PEG tube site care should be completed every day and as needed for increased drainage. She also revealed that since there was no dressing to her PEG tube site and due to the amount of drainage observed to the site, there was no way to tell when the last time it was cleaned. LPN #5 confirmed that failure to keep the PEG tube site clean and dry could lead to skin irritation and infection. An interview on 04/22/26 at 10:27 AM with Assistant Director of Nursing (ADON), revealed that her expectation was for nurses to follow the physician orders when providing resident care. She revealed that PEG tube sites should be cleaned every day and should be cleaned with soap and water or normal saline, and if there was an order for a dressing to be applied, it should be done. ADON agreed that failure to perform daily dressing changes as ordered by the physician, along with allowing drainage to accumulate around the PEG tube sites could result in infection. An interview on 04/22/26 at 10:33 AM with Registered Nurse (RN) #1, Infection Preventionist, revealed that they expected nurses to assess PEG tube sites daily and clean around the stomas with soap and water or normal saline. She revealed that she also expected nurses to review physician orders and provide the care accordingly. RN #1 revealed that failure to clean the PEG tube sites as ordered could result in skin irritation, burning of the skin, or infection. Record review of Resident #5's "Admission Record" revealed an original admission date of 08/07/20 and that she had diagnoses that included Alzheimer's Disease, Unspecified, Functional Quadriplegia, and Gastrostomy Status. Record review of Resident #5's "Medication Administration Record" with order date of 09/10/2025, revealed "Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin	F0880		

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F0880 SS = D	Continued from page 26 breakdown." Record review of Resident #5's "Order Summary Report" revealed an order with effective date of 09/10/25 documented, "Enteral Feed Order every day shift Cleanse peg tube stoma site with normal saline, pat dry. Apply dry drain dressing to avoid skin breakdown." RESIDENT #23 An observation and interview on 04/20/26 at 12:32 PM revealed Resident #23 lying in bed and he stated that he needed some help. He pulled his shirt up and exposed his PEG tube site which had a thick brown, crusted substance beneath the external skin disk which extended approximately one-half to three fourths of an inch to the surrounding area. Resident #23 revealed that the site had not been cleaned in approximately three days and stated, "Look at this, it's nasty" and "I want it out." Follow-up observations on 04/21/2026 at 8:30 AM and 3:08 PM confirmed that Resident #23's PEG tube site remained unclean with visible drainage. During an interview at 3:08 PM, Resident #23 stated, “I may have to clean it myself.” During an observation and interview on 04/21/2026 at 3:10 PM with Licensed Practical Nurse (LPN) #5, she confirmed the presence of thick, brown drainage and stated the site had not been cleaned in several days. LPN #5 revealed that PEG tube care should be performed daily and as needed to prevent infection and skin breakdown and stated she would take care of it now. During an observation and interview on 04/21/26 at 3:25 PM with Director of Nursing, she viewed Resident #23's PEG tube site and confirmed the dry crusty brown drainage and stated that this had not been cleaned in a while. She revealed that his PEG tube site should be cleaned every day and as needed. DON also revealed that not cleaning the site daily could cause skin irritation and possible infection. She revealed that she would get the treatment nurse to look at the site and they would take care of the issue. Record review of Resident #23's "Order Summary Report" revealed an order dated 09/10/25, "every day shift Cleanse peg tube stoma with soap and water rinse with clean water pat dry and leave open to air. Can apply dry dressing if drainage is	F0880		

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F0880 SS = D	Continued from page 27 present." Record review of Resident #23's "Admission Record" revealed an admission date 08/14/25 with diagnoses that included Unspecified Severe Protein-Calorie Malnutrition and Gastrostomy Status. Record review of Resident #23's MDS with ARD of 01/30/2026 under Section C indicated a BIMS score of 10, reflecting moderate cognitive impairment. Resident #54 During an observation of wound care to a Stage IV pressure injury to the sacrum on 4/22/2026 at 11:10 AM with the Treatment Nurse and CNA #3, when CNA #3 opened Resident #54's brief, the presence of stool was observed. CNA #3 obtained a clean brief and wipes and provided peri-care to clean the resident prior to wound care. Immediately after completing peri-care, CNA #3 removed the existing wound dressing and assisted with repositioning the resident by rolling her so her back faced the Treatment Nurse. The Treatment Nurse then performed wound care while CNA #3 assisted in holding the resident in position using the same gloves worn during peri-care. CNA #3 did not perform hand hygiene or change gloves between peri-care and wound care. During an interview on 4/22/2026 following wound care, CNA #3 stated she should have performed hand hygiene and changed gloves after providing peri-care and prior to assisting with wound care. She stated, "I just didn't bring extra gloves with me." During an interview on 4/22/2026 at 11:24 AM, the Treatment Nurse stated that CNA #3 should have performed hand hygiene after providing peri-care and confirmed that this could put the resident at risk for an infection. During an interview on 4/22/2026 at 12:14 PM, the DON and ADON confirmed hand hygiene should be performed after providing care and that CNA #3 should not have assisted with wound care without first performing hand hygiene and changing gloves. The DON stated this was an infection control concern. Record review of the "Admission Record" indicated that the facility admitted Resident #54 on 2/24/2026 with medical diagnoses that included Chronic	F0880		

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F0880 SS = D	Continued from page 28 Diastolic (Congestive) Heart Failure and Pressure Ulcer of sacral region, stage 4. A record review of the MDS with an ARD of 4/15/26 revealed under section C, a BIMS summary score of 3 which indicated Resident #54 was severely cognitively impaired.	F0880		