Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **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
M0000	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 4/20/26 through 4/23/26. During the survey the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M500, M610, M635, M655, M1000, M1015, and M1570. The SA identified non-compliance and cited M1570 for infection control for CI MS #2982050. The SA investigated CI MS #2976515 and CI MS #2982780 with no deficiencies cited. The census at the time of the survey was 130 and the facility was licensed for 140 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be	M0500		

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

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M0500	Continued from page 1 limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;	M0500		

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M0500	Continued from page 2 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal	M0500		

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M0500	Continued from page 3 decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, resident interviews, staff interviews, and facility policy, 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. During an interview on 4/22/2026 at 12:20 PM with	M0500		

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M0500	Continued from page 4 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 On 4/20/2026 at 10:15 AM, Resident #111 was sitting in the dayroom/dining area on the East/West halls	M0500		

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M0500	Continued from page 5 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.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These	M0610		

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M0610	Continued from page 6 shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, resident and staff interviews, 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 reviewed. (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. Record review of Resident #101 "Admission Record"	M0610		

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M0610	Continued from page 7 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.	M0610		
M0635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure percutaneous endoscopic gastrostomy (PEG) feeding administration was initiated to prevent	M0635		

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M0635	Continued from page 8 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. 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.	M0635		

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M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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. 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	M0655		

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M0655	Continued from page 10 a physician order for oxygen. She revealed the nurse admitting the resident was responsible for ensuring an order was in place. Record 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.	M0655		
M1000	45.34.3 Medical Waste Management Plan Medical Waste Management Plan. All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following: 1. Storage and Containment of Infectious Medical Waste and Medical Waste: a. Containment of infectious medical waste and medical waste shall be in a manner and location which affords protection from animals, rain and wind, does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to the public. b. Infectious medical waste shall be segregated from other waste at the point of origin in the producing facility. c. Unless approved by the licensing agency or treated and rendered non-infectious, infectious medical waste (except for sharps in approved containers) shall not be stored at a waste producing facility for more than seven days above a temperature of six (6) degrees Celsius (equivalent to thirty-eight [38] degrees Fahrenheit). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of zero (0) degrees Celsius (equivalent to thirty-two [32] degrees Fahrenheit) for a period of not more than ninety (90) days without specific approval of the licensing agency.	M1000		

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M1000	Continued from page 11 d. Containment of infectious medical waste shall be separate from other wastes. Enclosures or containers used for containment of infectious medical waste shall be so secured so as to discourage access by unauthorized persons and shall be marked with prominent warning signs on, or adjacent to, the exterior of entry doors, gates, or lids. Each container shall be prominently labeled with a sign using language to be determined by the licensing agency and legible during daylight hours. e. Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid wasted during storage, handling, or transport. f. All bags used for containment and disposal of infectious medical waste shall be of a distinctive color or display the Universal Symbol for infectious waste. Rigid containers of all sharps waste shall be labeled. g. Compactors or grinders shall not be used to process infectious medical waste unless the waste has been rendered noninfectious. Sharps containers shall not be subject to compaction by any compacting device except in the institution itself and shall not be placed for storage or transport in a portable or mobile trash compactor. h. Infectious medical waste and medical waste contained in disposable containers as prescribed above, shall be placed for storage, handling, or transport in disposable or reusable pails, cartons, drums, or portable bins. The containment system shall be leak-proof, have tight fitting covers and be kept clean and in good repair: i. Reusable containers for infectious medical waste and medical waste shall be thoroughly washed and decontaminated each time they are emptied by a method specified by the licensing agency, unless the surfaces of the containers have been protected from contamination by disposable liners, bags, or other devices removed with the waste, as outlined in I.E.	M1000		

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M1000	Continued from page 12 Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures: i. Exposure to hot water at least one-hundred eighty (180) degrees Fahrenheit for a minimum of fifteen (15) seconds. ii. Exposure to a chemical sanitizer by rinsing with or immersion in one of the following for a minimum of three (3) minutes: a. Hypochlorite solution (500 ppm available chlorine). b. Phenolic solution (500 ppm active agent). c. Iodoform solution (100 ppm available iodine). d. Quaternary ammonium solution (400 ppm active agent). iii. Reusable pails, drums, or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as noninfectious waste or for other purposed except after being decontaminated by procedures as described in 133.03 (i) of this section. j. Trash chutes shall not be used to transfer infectious medical waste. k. Once treated and rendered non-infectious, previously defined infectious medical waste will be classified as medical waste and may be land-filled in an approved landfill. 2. Treatment or disposal of infectious medical waste shall be by one of the following methods: a. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.	M1000		

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M1000	Continued from page 13 b. By sterilization by heating in a steam sterilizer, so as to render it noninfectious. Infectious medical waste so rendered non-infectious shall be disposable as medical waste. Operating procedures for steam sterilizers shall include, but not be limited to, the following: i. Adoption of standard written operating procedures for each steam sterilizer including time, temperature, pressure, type of waste, type of container(s), closure on container(s), pattern of loading, water content, and maximum load quantity. ii. Check or recording and/or indicating thermometers during each complete cycle to ensure the attainment of a temperature of one-hundred twenty-one (121) degrees Celsius (equivalent to two-hundred fifty [250] degrees Fahrenheit) for one-half (1/2) hour or longer, depending on quantity and density of the load, in order to achieve sterilization of the entire load. Thermometers shall be checked for calibration at least annually. iii. Use of heat sensitive tape or other device for each container that is processed to indicate the attainment of adequate sterilization conditions. iv. Use of the biological indicator Bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least monthly to confirm the attainment of adequate sterilization conditions. v. Maintenance of records of procedures specified in (i), (ii, (iii) and (iv) above for period of not less than a year. c. By discharge to the approved sewerage system if the waste is liquid or semi-liquid, except as prohibited by the Mississippi State Department of Health or other regulatory agency. d. Recognizable human anatomical remains shall be disposed of by incineration or internment, unless burial at an approved landfill is specifically authorized by the Mississippi State Department of Health. e. Chemical sterilization shall use only those chemical sterilants recognized by the U. S.	M1000		

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M1000	Continued from page 14 Environmental Protection Agency, Office of Pesticides and Toxic Substances. Ethylene oxide, glutaraldehyde, and hydrogen peroxide are examples of sterilants that, used in accordance with manufacturer recommendation, will render infectious waste non-infectious. Testing with Bacillus subtilis spores or other equivalent organisms shall be conducted quarterly to ensure the sterilization effectiveness of gas or steam treatment. f. Treatment and disposal of medical waste which is not infectious shall be by one of the following methods: i. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash. ii. By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land, and which is not a treatment facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview and facility policy review the facility failed to properly store regulated medical waste and failed to ensure the door to the biohazard storage building was secure for one (1) of four (4) survey days. Findings Include: Review of the facility policy "Regulated (Biohazard) Medical Waste" dated April 2026 revealed, "The center is to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidance and regulations..." An observation on 04/23/26 at 11:35 AM of the Biohazard Storage Building with the Maintenance Supervisor revealed an unlocked door to the inside. Inside the building, there were two large open biohazard boxes containing sharps containers overflowing above the top of the boxes. The biohazard boxes were not properly closed or sealed. Additionally, a large pile of biohazard waste, including soiled disposable briefs, soiled bed pads, and used IV (intravenous) tubing were observed on top of an opened red biohazard bag located on the floor. The Maintenance Supervisor confirmed that the door to the biohazard building was not locked and	M1000		

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M1000	Continued from page 15 this could allow unauthorized access and potential exposure to contaminated materials. He also confirmed that improper handling and storage of biohazard waste created an unsafe environment. An interview with the Director of Nursing (DON) revealed that the biohazard rooms and the outdoor biohazard storage building should be locked at all times to prevent unauthorized people from entering. She also revealed that biohazard waste should be stored and disposed of properly for safety reasons to prevent exposure to potentially harmful substances.	M1000		
M1015	45.35.2 Bathtubs, Showers, and Lavatories Bathtubs, Showers, and Lavatories. Bathtubs, showers, and lavatories shall be kept clean and in proper working order. They shall not be used for laundering or for storage of soiled materials. Neither shall these facilities be used for cleaning mops, brooms, etc. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to 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.	M1015		

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M1015	Continued from page 16 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 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,	M1015		

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M1015	Continued from page 17 indicating Resident #138 was cognitively intact.	M1015		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, 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..."	M1570		

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M1570	Continued from page 18 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) #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	M1570		

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M1570	Continued from page 19 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 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,	M1570		

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M1570	Continued from page 20 “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 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	M1570		

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M1570	Continued from page 21 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 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.	M1570		