STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255275	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA SENIOR CARE, LLC	**3701 PETER QUINN DRIVE , JACKSON, Mississippi, 39213**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 04/13/2026 through 04/16/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F0550, F0656, F0684, F851, and F880. The facility had a census of 55 and was licensed for 60 beds.	F0000		
F0656 SS = E	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 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	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 = E	Continued from page 1 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, interviews, record review and facility policy review the facility failed to implement comprehensive care plan by not following physician orders related to the application of compression hose, nurses cleaning and changing tubing on suction device and wearing Personal Protective Equipment (PPE) while providing direct care for three (3) of five (5) care observations. Resident #6, Resident #8, and Resident #22. Findings Include: Record review of the facility policy “Comprehensive Care Plans” revision date of 10/23 revealed, “It is the policy of this facility to develop and implement a comprehensive person- centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet resident’s medical, nursing and mental and psychosocial needs, that are identified in the resident’s comprehensive care assessment...” Resident #6 Record review of the “Care Plan Report” revealed “Focus: She has problems with chronic recurring edema to her (B) (bilateral) lower extremities…Intervention…Apply her (B) knee-high compression hose q (every) AM and remove at HS (hour of sleep) per MD orders…” On 04/13/26 at 11:20 AM, during an observation and interview, Resident #6 was observed in bed and	F0656		

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F0656 SS = E	Continued from page 2 stated, "My legs are swollen and I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch." She pulled the bed covers back and the State Agency (SA) observed her legs were swollen and she had red slip free socks on. On 04/13/26 at 2:13 PM, during an interview and observation with Licensed Practical Nurse (LPN) #1 confirmed that Resident #6 did not have compression hose on. She stated they should be put on daily. On 04/16/26 at 2:40 PM in a phone interview with CNA #1stated Resident #6 stated residents went to bingo at 2:00 PM and the resident did not want the compression hose on. The SA informed CNA #1 that Resident #6 did not go to bingo and that LPN #1, and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond. On 04/14/26 at 2:54 PM, in an interview the Director of Nursing (DON) stated the purpose of compression hose is to decrease swelling and increase circulation through the body. She stated her expectations for CNAs to put hose on in the AM after breakfast. Record review of the "Admission Record" revealed an admission date of 10/14/21 with diagnosis of personal history of other venous thrombosis and embolism and localized edema. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicates the resident is cognitively intact. Record review of the “Order Summary Report” revealed a physician order dated 8/3/22 “Apply bilateral knee-high compression hose every AM (morning) and remove at HS (hour of sleep) every day and night shift for edema. Resident #8 Record review of the “Care Plan Report” revealed “Focus: He is at risk for complications related to his use of a feeding tube...Interventions… Observe Enhanced Barrier Precautions when providing care (ie: dressing, bathing, transfers, personal hygiene, changing linen incont (incontinent) care.” On 04/15/26 2:32 PM, during an observation of Resident #8 receiving perineal (peri) care revealed CNA#2 provided care without wearing a gown.	F0656		

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F0656 SS = E	Continued from page 3 Resident #8 is on Enhanced Barrier Protection (EBP) due to a percutaneous endoscopic gastrostomy (peg) tube. On 04/15/26 2:46 PM, in an interview with CNA #2, she confirmed she did not wear a gown while providing peri-care. She stated the purpose of the gown to prevent transferring infections to the resident. She stated she placed the resident at risk for infection by not wearing a gown. Record review of Resident #8 "Admission Record" revealed an admit date of 5/18/17 with diagnoses that included hemiplegia and hemiparesis, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Record review of the MDS with an ARD of 4/2/26 revealed a BIMS score of 13 indicating the resident was cognitively intact. On 04/16/26 at 10:48 AM, in an interview the DON stated CNA#2 should have donned (put on) a gown before providing peri care. She stated Resident #8 is on EBP due to the peg tube. She stated staff should wear gowns anytime they are doing high contact care. She stated that peri care is high contact care. She stated her expectation of staff while doing care on residents who are on EBP, is that they give proper and adequate care. She stated CNA #2 placed Resident#8 at higher risk of infection by not wearing a gown. Resident #22 Record review of the “Care Plan Report” revealed “…Ensure equipment is cleaned per facility protocol. Ensure equipment is set up and properly working for use. Instruct her to inform staff when she uses the suction machine so that the nurse may document accordingly…” On 04/13/26 at 11:28 AM, an interview and observation revealed Resident #22 sitting up in bed watching TV. Resident #22 had suction set up on the bedside table. She stated," I have swollen issues and suction myself." The yankauer is dated 9/15/25, the yanker and tubing were dingy yellow, cloudy. On 04/14/26 10:19 AM in an interview and observation of Resident #22 with LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse’s	F0656		

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F0656 SS = E	Continued from page 4 responsibility to change tubing and yankauer, not the family. On 04/14/26 at 10:26 AM, an interview the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 "is our resident and our responsibility." She stated, "we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly." She stated family doing it could cause the resident to get a respiratory infection. On 04/14/26 at 10:30 AM, in an interview and observation in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. On 04/14/26 at 12:10 PM, in an interview the DON stated they do not have assessment of Resident #22's ability to properly perform self-oral suctioning. She stated they should have completed one to make sure she can suction correctly and safely. On 04/16/26 at 9:28 AM, during a phone interview with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows he does it. On 04/16/26 at 10:53 AM, in an interview the DON stated care plans are individualized. She stated it informs the staff of the care residents require and they should follow it. She stated CNA #1, #2, and nurses did not follow care plan. On 04/16/26 at 11:03 AM, in an interview with Registered Nurse (RN)# 1/MDS nurse stated the care plan is used by all staff to give care. She stated she expects staff to use it while providing care. She stated staff can't give adequate care if they do not follow care plan.	F0656		

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F0656 SS = E	Continued from page 5 Record review of Resident #22's "Admission Record" revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease. Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's "Order Summary Report" revealed an order dated 11/17/25 "Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed "Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed "Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently." Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine.	F0656		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to follow physician orders, as evidenced by not applying compression hose for a resident and not cleaning suction equipment for two (2) of (2) residents reviewed. Resident #6 and #22. Findings Include: Record review of the facility policy "Provision of Quality Care" dated 2025, revealed, "Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice…Each resident will be provided with care and services to attain or maintain his/her	F0684		

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F0684 SS = E	Continued from page 6 highest practicable physical, mental and psychosocial well-being..." Resident #6 During an observation and interview on 04/13/2026 at 11:20 AM, Resident #6 was observed in bed and stated, "My legs are swollen and I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch." She pulled the bed covers back and the State Agency (SA) observed her legs were swollen and she had red slip free socks on. During an interview and observation on 04/13/2026 at 2:13 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #6 did not have compression hose on. She stated they should be put on daily. In a phone interview on 04/16/2026 at 2:40 PM, CNA #1 stated Resident #6 went to bingo at 2:00 PM and the resident did not want the compression hose on. The SA informed CNA #1 that Resident #6 did not go to bingo and that LPN #1, and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond. Record review of the "Admission Record" revealed an admission date of 10/14/21 with diagnosis of personal history of other venous thrombosis and embolism and localized edema. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicates the resident is cognitively intact. Record review of the “Order Summary Report” revealed a physician order dated 8/3/22 “Apply bilateral knee-high compression hose every AM (morning) and remove at HS (hour of sleep) every day and night shift for edema. Resident #22 During an interview and observation on 04/13/2026 at 11:28 AM, revealed Resident #22 sitting up in bed watching TV. Resident #22 had suction set up on the bedside table. She stated," I have swollen issues and suction myself." The yankauer is dated 9/15/25, the yanker and tubing were dingy yellow, cloudy. During an interview and observation with Resident #22 on 04/14/2026 10:19 AM, LPN #1 confirmed the	F0684		

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F0684 SS = E	Continued from page 7 tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse's responsibility to change tubing and yankauer, not the family. During an interview on 04/14/26 at 10:26 AM, the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 "is our resident and our responsibility." She stated, "we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly." She stated family doing it could cause the resident to get a respiratory infection. During an interview and observation on 04/14/26 at 10:30 AM, in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. During an interview on 04/14/26 at 12:10 PM, the DON stated they do not have an assessment of Resident #22's ability to properly perform self-oral suctioning. She stated they should have completed one to make sure she can suction correctly and safely. During a phone interview on 04/16/26 at 9:28 AM, with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows he does it. During an interview on 04/16/2026 11:08 AM, Registered Nurse #1 (RN)/MDS stated a nurse is supposed to assess Resident #22 to make sure she can suction herself. Record review of Resident #22's "Admission Record" revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and	F0684		

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F0684 SS = E	Continued from page 8 Dysphagia following Cerebrovascular Disease. Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's "Order Summary Report" revealed an order dated 11/17/25 "Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed "Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed "Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently." Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine.	F0684		
F0851 SS = E	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct	F0851		

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F0851 SS = E	Continued from page 9 care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete submission of staffing data through the Payroll-Based Journal (PBJ) system to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) FY (fiscal year) quarters reviewed. This deficient practice had the potential to result in inaccurate public reporting of staffing levels and misrepresentation of the facility's actual staffing, including the omission of contract nursing staff hours. Findings included: Record review of the facility policy titled "Payroll Based Journal," dated 2025, revealed "It is the policy of this facility to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and	F0851		

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F0851 SS = E	Continued from page 10 contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS..." During an interview on 04/16/2026 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA) stated he is responsible for compiling and submitting PBJ data to the CMS portal. He stated employee staffing data is received from the corporate office through a software generated file and used for PBJ submission. He stated contract nursing staffing data is received separately from vendors and manually entered into the PBJ system. The LNHA stated he was not aware of any errors in the PBJ data submitted for the first quarter and provided documentation supporting the submitted data. Upon further investigation, the LNHA stated the data transmitted from the corporate software system was not accurately submitted to the CMS PBJ system. He confirmed contract nursing staffing data for 10/25/2025, 11/22/2025, 12/06/2025, 12/19/2025, 12/27/2025, and 12/28/2025 was not included in the PBJ submission. Record review of PBJ submission documentation confirmed contract nursing staffing hours for the identified dates were not included in the data submitted to CMS. Record review of the “PBJ Staffing Data Report” for FY (Fiscal Year) Quarter 1 2026 (October 1-December 31) revealed “This staffing Data Report identifies areas of concern that will be triggered…Excessively Low Weekend Staffing…” During an interview on 04/14/2026 at 1:15 PM, the LNHA confirmed the facility utilized contract nursing staff. During an interview on 04/16/2026 at 11:00 AM, the Director of Nursing (DON) stated she and the Staffing Coordinator are responsible for staffing. She stated staffing is based on resident acuity and the facility assessment. She stated Unit Supervisors may adjust schedules to maintain coverage. She confirmed the current schedule supports a census of 55 residents and call outs are managed without staffing issues. Record review of staffing schedules and daily staffing sheets revealed no staffing shortages or concerns.	F0851		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA SENIOR CARE, LLC	**3701 PETER QUINN DRIVE , JACKSON, Mississippi, 39213**

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F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F0880		

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F0880 SS = E	Continued from page 12 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection as evidenced by not wearing proper personal protective equipment (PPE) and not adhering to Enhanced Barrier Precautions (EBP) during high contact care, not performing hand hygiene prior to care and not protecting a yankeaer from bacteria, changing tubing, and cleaning a suction device for three (3) of five (5) care observations. Resident# 8, Resident #22 and Resident #49. Findings include: Record review of the facility policy “Hand Hygiene Policy” dated 2025 revealed, “Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors... Before performing residents care procedures…” Record review of the facility policy “Enhanced Barrier Precautions” dated 2025 revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high	F0880		

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F0880 SS = E	Continued from page 13 contact resident care activities. Resident #8 On 04/15/2026 at 2:32 PM, during an observation Resident #8 received peri care from Certified Nursing Assistant (CNA) #2. Resident #8 had a percutaneous endoscopic tube (peg) tube and was on EBP. Resident #8 had a bowel movement. CNA did not have a gown on as she was performing perineal (peri) care. On 04/15/2026 at 2:46 PM, in an interview with CNA #2 she confirmed she did not have a gown on while providing peri care. She stated the purpose of the gown to prevent transferring infections to the resident. She stated she placed resident at risk for infection by not wearing a gown. On 04/16/2026 10:48 AM, in an interview with the Director of Nursing (DON) stated CNA#2 should have donned (put on) a gown before doing peri care. She stated Resident #8 is on EBP due to the peg tube. She stated staff should wear gowns anytime they are doing high contact care. She stated her expectation of staff while doing care on residents who are on EBP, is that they give proper care and adequate care. Peri care is high contact care. She stated CNA #2 placed the resident at higher risk for infection by not wearing a gown. Record review of Resident #8 "Admission Record" revealed an admit date of Hemiplegia and Hemiparesis' following unspecified Cerebrovascular Disease affecting left non-dominant side, Personal History of Transient Ischemic attack (TIA) and Cerebral Infarction without residual deficits and Dysphagia unspecified. Record review of Resident #8 Minimum Data Set (MDS) Assessment Reference Date 4/2/26 with a Brief Interview of Mental (BIMS) score of 13, which indicates cognitively intact. Section GG reveals he is dependent on hygiene. Resident #22 On 04/13/2026 at approximately 11:28 AM in an interview and observation of Resident #22 sitting up in bed watching TV. Resident #22 has suction set up on the bedside table. Resident #22 picks up canker and uses tip of canker to turn it on and then placed canker in her mouth to suction. The canker was on the bed exposed to bacteria. There was no covering or shield to protect it from bacteria. After suction she uses the tip to turn it off and places it on her	F0880		

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F0880 SS = E	Continued from page 14 bed not enclosed in a zip lock bag. During the interview and observation Resident #22 uses canker to suction three times each time using the tip to turn suction on and off. The canker is dated 9/15/25, the canker and tubing are dingy yellow, cloudy. On 04/13/26 at 2:30 PM, during an observation of Resident #22 suctioning herself revealed she used same technique that she had used the previous time. On 04/13/26 at 2:52 PM, during an observation of Resident #22 suctioning herself and placing the yankeaer on bed. She continued to use the of exposed canker to turn it on and off as she used it. On 04/14/2026 10:19 AM in an interview and observation of Resident #22 with LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse's responsibility to change tubing and yankauer, not the family. On 04/14/26 at 10:26 AM, an interview the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 "is our resident and our responsibility." She stated, "we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly." She stated family doing it could cause the resident to get a respiratory infection. On 04/14/26 at 10:30 AM, in an interview and observation in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. On 04/16/26 at 9:28 AM, during a phone interview with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows	F0880		

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F0880 SS = E	Continued from page 15 he does it. Record review of Resident #22's "Admission Record" revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease. Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's "Order Summary Report" revealed an order dated 11/17/25 "Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed "Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed "Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently." Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine. Resident #49 On 04/15/2026 at 2:10 PM, during an observation of CNA #2 revealed she entered Resident #49's room and pulled gloves from the box and donned (put on) them. CNA#2 assisted the resident to the bed, removed his pants and shoes. She then removed her gloves and exited the room. On 04/15/2026 at 2:23 PM, CNA #2 returned to Resident #49's room and put on gloves. She retrieved peri wipes out of the drawer with gloves on. She provided peri care for Resident #49. She did not perform hand hygiene prior to either of the care observations. On 04/15/2026 at 2:43 PM, in an interview with CNA #2 she confirmed that she did not wash or sanitize her hands either time she entered the room to provide care to Resident #49. She stated "I sanitized my hands in the hallway before entering the room." She stated Resident #49 could get infection from her not performing hand hygiene. On 04/16/2026 at 10:43 AM, in interview with the Director of Nursing (DON) confirmed CNA #2 should have washed her hands before and after care and that she should have changed gloves after opening the drawer to get peri wipes. She stated CNA #2 placed the resident at increase for infection.	F0880		

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F0880 SS = E	Continued from page 16 Record review of Resident #49 "Admission Record" revealed an admission date of 3/17/2017 with diagnoses that included Parkinson disease with dyskinesia, with fluctuations and urinary tract infection. Record review of Resident #49's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Section GG revealed Resident #49 is dependent on hygiene. On 04/16/2026 12:16 PM, in an interview with RN #2/ Infection Preventionist (IP) nurse stated that CNA #2 should have performed hand hygiene upon entry before starting peri care on Resident #8. She stated Resident #8 could get an infection by CNA #2 giving care without a gown in place. She stated the resident is on EBP due to a peg tube. She stated Resident #22 yankeaer should have been in a bag to prevent contamination tubing should have been changed and device should have been cleaned by nurse. She stated Resident #22's yankeaer should have been placed in a bag to prevent cross contamination. She stated that Resident #22 was put at risk for a mouth or bacterial infection or bacterial infection. She stated Residents #8, #22 and #49 were all placed on higher risk for infection.	F0880		
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	F0550		

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F0550 SS = D	Continued from page 17 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 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, interviews, record review and facility policy review the facility failed to honor residents' rights as evidenced by posting of personal signage in the resident's room for one (1) of (14) residents reviewed. Resident #6. Findings Include: Record review of the facility's "Resident Rights Policy" dated 2025 revealed the facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the facility's responsibility to provide proper care to residents. On 04/13/2026 at 11:20 AM, during an observation and interview revealed Resident #6 was in bed. Observed signage on the wall "Please put on compression hose daily even when resident is in bed. They are to be removed every night at bedtime" Resident #6 stated, "my legs are swollen, I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch." Resident #6 pulled her bed covers back and her legs were swollen. She had red slip free socks on. She stated the facility put that sign on the wall and stated, "I guess it is to remind them to do it, but they still don't". On 04/13/2026 at 2:13 PM, during an interview and observation with Licensed Practical Nurse #1 (LPN)	F0550		

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F0550 SS = D	Continued from page 18 of the h on the signage on the wall. She stated the signage on the wall is to notify the CNAs to put on the compression hose. She confirmed the CNAs have a Kardex and the task pops up daily to remind them. She confirmed that Resident #6 did not have them on. She stated they should be on daily. On 04/14/26 at 2:54 PM, in an interview with Director of Nursing (DON) stated the signage posted in the room is a dignity issue. She stated it should not be on the wall. She stated CNAs should have placed compression hose on in the morning. She stated the reminder for the CNA shows up in "task." She stated that it is their reminder. She stated the purpose of compression hose is to decrease swelling and increase circulation through the body. She stated her expectations for CNAs to put hose on in the morning after breakfast. On 04/16/2026 at 2:40 PM, in a phone interview with CNA #1 stated Resident #6 went to bingo at 2:00 PM and did not want them on. The State Agency (SA) informed CNA #1 that Resident #6 did not go to bingo, that LPN #1 and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond. Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 10 /14/21 with diagnoses that included personal history of other venous thrombosis and embolism and localized edema. Record review of Resident #6 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) of 13 which indicated the resident was cognitively intact. Record review of the "Order Summary Report" revealed apply bilateral knee-high compression hose every AM and remove at sleep every day and night shift for edema.	F0550		