STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255314	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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WASHINGTON CARE CENTER	**1920 LISA DRIVE EXTENDED , GREENVILLE, Mississippi, 38703**

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F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with a Complaint Investigation (CI MS #2962685) at the facility from 4/28/26 through 4/30/26. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies at F641, F656, F677, F812, and F883. There were no deficiencies cited for CI MS #2962685 related to abuse, neglect, and resident rights. The census at the time of the survey was 52 with a bed capacity of 60 beds.	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812		

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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F0812 SS = F	Continued from page 1 Based on observation, staff interviews and facility policy review the facility failed to ensure items in the kitchen refrigerator were dated and labeled and failed to discard food items by the expiration date for one (1) of three (3) dietary tour observations. Findings Include: Review of the facility policy titled, “Food Storage Labeling,” with a revision date of 08/12, revealed “The facility will ensure the safety and quality of food by adhering to proper storage and labeling procedures. 1. a. All temperature-controlled foods and ready to eat foods that are prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the Food, Date of storage. b. Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufacturer use-by date or expiration date...” An observation and interview on the initial tour of the kitchen on 04/28/2026 at 10:15 AM, with the Dietary Manager (DM) revealed in refrigerator number two (#2) a plastic gallon-size bag with no date and no label, the DM identified the item as shredded carrots, and a 2-gallon bag of salad mix with no open date. The DM stated, “I’m really not sure when these were opened.” A five (5) pound white container with a manufacturer's label cottage cheese and dated 12/31/25, a one-gallon container with a manufacturer's label Lime Juice with an opened date of 6/25/25 and best by date of 9/17/25 by the manufacturer's label on the container. A plastic one-gallon container with a manufacturer's label of classic coleslaw with an open date of 10/22/25 and no expiration date. A gallon of manufactured 2% milk with approximately one-half remaining in the jug, with a best-by date of April 18 on the jug. The DM revealed that all foods should be labeled and dated, and that expired foods should be discarded. During an interview on 04/29/2026 at 11:10 AM, Dietary Worker #1 stated that it is everyone’s responsibility to ensure the food is labeled and dated and that expired food is discarded. She stated, “Food items that are opened and placed in the refrigerator are only supposed to be in there for four days.” During an interview on 04/29/2026 at 11:25 AM, the Dietary Manager confirmed all foods should be labeled, dated, and discarded when expired to prevent spoilage and illness. The DM further confirmed that while all staff share responsibility for	F0812		

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F0812 SS = F	Continued from page 2 labeling, dating, and discarding expired foods, oversight of this process ultimately rests with her as the Dietary Manager.	F0812		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code Section A of the Minimum Data Set (MDS) for a resident identified with a serious mental illness (SMI) through the Preadmission Screening and Resident Review (PASRR) Level II process for one (1) of (16) MDS assessments reviewed. Resident #9	F0641		

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F0641 SS = D	Continued from page 3 Findings include: Review of the facility policy titled “Resident MDS Assessment,” revised 9/9, revealed, “An assessment will be completed on each resident utilizing the MDS… The completed assessment guides staff in identifying key information about the resident and serves as a basis for identifying resident-specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental, and psychosocial well-being...” Record review of Resident #9’s “Preadmission Screening and Resident Review Summary of Findings Report,” dated 5/8/23, revealed under “Mental Health," the individual meets criteria for having a diagnosis of mental illness as defined by PASRR. The report further revealed diagnoses including Axis I Primary: Major Depressive Disorder, Axis I Secondary: Anxiety Disorder, and Axis I Tertiary: Bipolar Disorder. Record review of the MDS with an Assessment Reference Date (ARD) of 1/21/26 revealed under section A1500 that Resident #9 was not considered by the state Level II PASRR process to have a serious mental illness, which was coded inaccurately. An interview with the Registered Nurse (RN) Case Manager on 4/29/26 at 2:59 PM, revealed Resident #9 did have a serious mental illness requiring a Level II PASRR evaluation. The RN confirmed she made an error on the MDS and stated the MDS should be accurate to ensure Resident #9 receives the appropriate care and services for her mental health disorders. Record review of the “Face Sheet” revealed the facility admitted Resident #9 on 4/21/23 with medical diagnoses including bipolar disorder and anxiety disorder. Record review of the MDS with an ARD of 1/21/26 revealed under section C, a BIMS summary score of 15, indicating Resident #9 was cognitively intact.	F0641		

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656		

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F0656 SS = D	Continued from page 5 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the implementation of the resident's care plan for oral hygiene for one (1) of (16) care plans reviewed. Resident #4 Findings Include: Record review of the facility policy titled "Care Plan Process," revised 12/24, revealed, "The facility shall use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. The facility staff shall follow the care plan." Record review of Resident #4's "Care Plan Report" revealed under, "Focus: Resident is dependent with oral hygiene." Further review revealed under, "Interventions: Provide oral hygiene as needed. Provide X (times) 1 (one) staff with oral care at least two times a day & (and) or as indicated." On 4/29/26 at 12:58 PM, observation of Resident #4 revealed he was lying in bed and was non-verbal. The resident's lips were dry with dried particles of peeling skin noted on the lower lip. The lower teeth were covered in a light orangish-colored substance with yellowish-green secretions observed inside the oral cavity. The tongue was coated with a thick yellowish-white substance. An observation and interview with Licensed Practical Nurse (LPN) #2 on 4/29/26 at 1:11 PM, confirmed lack or oral care describing Resident #4's lips as dry and the tongue as coated with secretions. An interview with the Registered Nurse (RN) Case Manager on 4/29/26 at 2:59 PM revealed Resident #4's care plan was in place so that staff knew what care to perform. She confirmed the care plan for oral care should have been followed. Record review of the "Face Sheet" revealed the facility admitted Resident #4 on 1/23/26 with medical diagnoses including Encounter for Attention to Gastrostomy, Cough, and Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26	F0656		

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F0656 SS = D	Continued from page 6 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #4 was cognitively intact.	F0656		
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 observation, staff interview, record review, and facility policy review, the facility failed to provide oral care to a resident dependent on staff for Activities of Daily Living (ADLs) care for one (1) of three (3) residents reviewed for ADLs. Resident #4 Findings Include: Review of the facility policy titled “Oral Hygiene,” revised 1/24, revealed under “Purpose”: To clean the mouth, teeth, and gums; To remove particles of food; To remove bacteria and odor; To provide comfort to the resident; To keep the mouth moist. Record review of Resident #4’s “Order Summary Report” revealed an order dated 1/23/26 for “NPO (nothing by mouth) diet.” An observation on 4/28/26 at 10:38 AM revealed Resident #4 was lying in bed with upper and lower lips that were dry, with cracking and peeling skin on the lower lip. The resident’s lower teeth were covered in a thick white substance. An observation on 4/29/26 at 12:58 PM revealed Resident #4 was lying in bed and was non-verbal. The resident’s lips were dry with dried particles of peeling skin noted on the lower lip. The lower teeth were covered in a light orangish-colored substance with yellowish-green secretions observed inside the oral cavity. The tongue was coated with a thick yellowish-white substance. An observation and interview with Certified Nurse Aide (CNA) #1 on 4/29/26 at 1:06 PM, revealed the aides were responsible for providing oral care to	F0677		

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F0677 SS = D	Continued from page 7 Resident #4. She stated she had already performed oral care earlier that morning but indicated the secretions must have built back up. Record review of Resident #4's "Personal Hygiene Task" dated 4/29/26 revealed no documentation that oral care was provided during that shift. An observation and interview with Licensed Practical Nurse (LPN) #2 on 4/29/26 at 1:11 PM, described Resident #4's lips as dry and the tongue as coated with secretions. She confirmed that if oral care had been performed, it was not completed appropriately and stated the resident's lips should have been moisturized. An observation and interview with the Director of Nursing on 4/29/26 at 1:20 PM, revealed oral care was considered part of personal hygiene provided by the aides. She confirmed Resident #4's poor oral care could lead to tooth decay and other health concerns and stated it was the charge nurse's responsibility to follow behind the aides to ensure care was provided. Record review of the "Face Sheet" revealed the facility admitted Resident #4 on 1/23/26 with medical diagnoses including Encounter for Attention to Gastrostomy, Cough, and Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #4 was cognitively intact. Also revealed under section GG, the resident was dependent on staff for oral care.	F0677		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side	F0883		

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F0883 SS = D	Continued from page 8 effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883		

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F0883 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the administration of the influenza vaccine in accordance with facility policy to prevent the spread of infection for one (1) of five (5) residents reviewed for immunizations. Resident #10. Findings Include: Review of the facility policy titled “Influenza Vaccination Program for Employees and Residents,” revised 1/24, revealed, “It is the policy of this facility to provide employees and residents with influenza vaccination every year between October and March. This is consistent with recommendations from the CDC (Center for Disease Control and Prevention) and state and local health departments.” Record review of Resident #10’s “Vaccine Information and Consents” revealed the Responsible Representative (RR) consented for the resident to receive the annual influenza vaccine on 2/3/26. Record review of Resident #10’s “Clinical Immunizations” revealed that under “Influenza Seasonal,” the resident was documented as not eligible for the vaccine. The record also indicated the resident was admitted after flu season, with this entry dated 2/3/26. An interview with the Infection Preventionist (IP) on 4/30/26 at 9:52 AM, confirmed she did not administer the influenza vaccine to Resident #10. She stated she documented the vaccine as out of season, acknowledging that flu season usually peaks in February, which was when the resident was admitted. The IP further confirmed the resident should have been vaccinated, stating it was important to prevent the spread of infections and illness, particularly in elderly residents. An interview with the Director of Nursing on 4/30/26 at 10:02 AM, revealed the facility should have vaccinated Resident #10 for influenza, confirming it was not out of season and emphasizing the importance of preventing the spread of infection. Record review of the “Face Sheet” revealed the	F0883		

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F0883 SS = D	Continued from page 10 facility admitted Resident #10 on 2/5/26 with medical diagnoses including Type 2 Diabetes Mellitus without Complications and Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #10 was severely cognitively impaired.	F0883		