STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chadwick Nursing and Rehabilitation Center LLC	1900 Chadwick Drive Jackson, MS 39204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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 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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews, record review, and facility statement review the facility failed to issue a bed-hold notice when a resident went out on therapeutic leave for one (1) of two (2) residents reviewed for discharge. (Resident #1).Findings Include:Record review of a typed statement on facility letterhead and signed by the Executive Director (ED) revealed, The facility does not have a policy for Bed Hold. On 09/15/25 at 4:42 PM, in an interview the ED stated Resident #1 was discharged due to escalating behavior. She would pull her dress while walking down the hall and go into male residents' rooms. She stated Resident #1 was discharged for her safety and welfare. She stated the facility could not meet her needs. She stated Resident #1's family declined the 30-day notice. Resident#1 left on 5/30/25 and family decided to take resident home. Resident was discharged on 5/30/25 due to the family decision.On 09/16/25 at 10:58 AM, a phone interview with Resident #1's Resident Representative (RR) stated that Resident #1 is with her sister at this time. The RR stated he received only one letter from the facility, and it was certified. He stated it took him a while to get the letter because he works nights and by the time he woke up post office was closed. He stated he was given a second discharge letter when he came to pick up personal belongings and medication on 6/2/25. He stated he was not aware and did not understand the appeal process. He stated he contacted the Ombudsman and was told there was nothing he could do about it. The RR stated when her sister picked up Resident #1 on 5/30/25 they did not inform her that Resident #1 was being discharged . The RR stated her sister tried to bring her back Sunday and was told resident was discharged on Friday. He stated Resident #1 did not have enough medications for all those days. He stated when Resident #1 left Friday they did not remove the wander guard, and it is still attached to her leg now. He stated if she was discharged on 5/30/25 they should have removed the wander guard at that time. He stated they only gave her enough medicine for the three (3) days she was on leave with her sister. He stated when her sister tried to return her Sunday, they met them at the door and told them she couldn't bring her back. He stated she requires help with activity of daily living (ADL) care, and they did not provide home health. The RR stated the facility contacted him to come get her personal belongings and medication.On 09/16/25 at 12:09 PM, in an interview the Social Worker (SW) stated that Resident #1 was not eligible for home health, and she has Medicaid. She stated home health requires Medicare. She stated she could not set it up because the resident did not have a payor source. She stated Resident#1 went on an outing on 5/30/25 with family and did not return and she was discharged when she did not return to the facility.On 09/16/25 at 1:07 PM, during an interview, the Director of Nursing (DON) started Resident #1 left on 5/30/25 and the facility knew she was not coming back. She stated the resident was discharged on 5/30/25 and family was aware. She stated a nurse phoned her and told her resident was leaving and she informed nurse to give the resident her medication. She stated she told nurse that she would contact the RR about picking up personal belongings and medication. She stated the RR came back Monday to pick up medications and instructions on how to give medication. She stated the residents have supportive families and would go on leave often with family. The DON stated the RR would have to come back Monday to get all medications and personal items. They only give personal items to the RR.On 09/16/25 at 1:45 PM, an interview with Business Office Manager (BOM) stated there are two types of bed hold. There is a 15-day bed hold when a resident goes out on therapeutic leave. She stated when a resident goes on therapeutic leave, they do not notify the family about bed hold. On 09/16/25 at 3:18 PM, in an interview with the ED, she stated therapeutic leave is when a resident leaves the facility with family. The family lets the facility know and the nurse documents in the chart, give medication to the family for the days out. She stated she calls therapeutic leave out on pass. She stated Resident #1 was out on a pass on 5/30/25 with family. She stated she found out Monday that Resident #1 did not return. She stated the resident returns on Sunday or Monday. She stated she was informed on Monday that the RR came to pick up personal items and all medications. She stated they do not give bed hold letters to family or residents when they go on therapeutic leave. She stated they only give them when resident goes to hospital and is admitted for 24 hours or more. She stated the facility has never given out bed hold letters for therapeutic leave. She stated she has been the ED at the facility for one year and 7 months.On 09/16/25 at 8:31 PM, in a phone interview with Resident #1's sister she stated she picked up Resident #1 on 5/30/25. She stated that her and the other sister take turns picking her up on the weekends. They each do two weeks out of the month. She stated when she picked up the resident nobody informed her of a discharge. She stated a nurse asked when the resident was coming back and she told them Sunday at 2:00 PM. She started to return

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan while providing perineal care for one (1) of two (2) residents observed for activities of daily living (ADL) care (Resident #4).Findings Include:A record review of the facility's Comprehensive Person-Centered Care Plans dated 1/25 revealed, Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences and goals that will identify how the interdisciplinary team will provide care .A record review of Resident #4's Care Plan Report revealed a care plan with an initiation date of 10/2/24, Focus: (Proper name of Resident #4) is incontinent of bladder and bowel.Interventions. Incontinent checks/care every two (2) hours and as needed (PRN) x (times) 2-person assistance for total dependence . On 9/16/25 at 4:03 PM, during an observation of perineal care revealed CNA #1 provided perineal care without 2-person assistance as indicated on the care plan. On 09/16/25 at 4:16 PM, during an interview CNA #1 confirmed that he did not follow the care plan by using 2 persons for assistance with perineal care. On 09/16/25 at 5:08 PM, in an interview with Executive Director (ED) she stated, All CNAs should be able to provide care correctly.On 09/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA#1 did not follow the care plan. She stated her expectation is for CNA's is to give good quality care and follow proper procedure for giving care.On 09/17/25 at 12:55 PM, during an interview Registered Nurse (RN) #2/Minimum Data Set (MDS) nurse stated she could not comment on what CNA #1 did or did not do, she was not there when he provided the care. She stated I can only say what the care plan says. The care plan states (2) people assistance with peri care. She stated the purpose of the care plan is to inform the CNAs of the care that is to be provided. She stated the interventions indicate what the facility is doing for the residents. A record review of Resident #4's admission Record revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting the right side, Dysphasia following unspecified cerebrovascular disease, Aphasia following unspecified cerebrovascular disease, and Gastroesophageal Reflux Disease without esophagitis.A record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was unable to complete the interview.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interviews, record reviews and facility policy review the facility failed to provide perineal (peri-care) according to acceptable standards for one (1) of two (2) observations. Resident #4. Findings Include:A record review of the facility's Incontinent Care dated 07/12 revealed .10. Wash the resident's entire perineal area, and all areas affected by incontinence with a washcloth, soap, warm water, peri-wash or wipes. 11. When washing perineal area, wash the entire perineal, wash the entire area.On 09/16/25 at 4:03 PM, in an observation, Certified Nursing Assistant #1 (CNA) provided perineal care for Resident #4. CNA #1 placed the feeding pump on hold. He used three wipes and wiped front to back in the groin area on the right side. He then folded the wipe and wiped the same area again. He retrieved three (3) more wipes and wiped the left side front to back. He picked up the remaining wipes and wiped down the center of the vagina front to back one time. He turned resident on her left side to remove soiled brief. He placed soiled brief on the bed and placed a clean brief on the resident. CNA#1 did not separate the labia and wipe down each side and the center. He did not clean the rectal area. On 9/16/25 at 4:16 PM, during an interview CNA #1 stated he had been trained to place the feeding pump on hold during care. He confirmed that he did not perform perineal care correctly. He stated he was nervous and forgot to follow proper procedure. CNA #1 acknowledged that his actions could cause Resident #4 to develop an infection.On 9/16/25 at 4:21 PM, during an interview Registered Nurse (RN) #2/ Unit Manager for the B Unit confirmed that CNA #1 did not provide care properly. She stated CNAs are not permitted to operate feeding pumps and that only nurses are authorized to do soOn 9/16/25 at 5:08 PM, during an interview the Executive Director (ED) stated that the State Agency (SA) should have picked anyone other than him to do peri care. She further stated all CNAs should be able to perform care correctly.On 9/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA #1 should have informed the nurse so she could place the feeding pump on hold, as CNAs are not permitted to operate feeding pumps. The DON stated the pump could malfunction and cause harm to the resident if not handled properly. The DON further stated CNA #1 should have performed perineal care correctly, including applying clean gloves before providing care to the buttocks and skin folds. She stated CNA #1 did not provide care correctly. The DON stated her expectation is for CNAs to provide quality care and to follow proper procedures when giving care.A record review of Resident #4's admission Record revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting the right side, Dysphasia following unspecified cerebrovascular disease, Aphasia following unspecified cerebrovascular disease, and Gastroesophageal Reflux Disease without esophagitis.A record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was unable to complete the interview.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to provide perineal care in a manner that would prevent the possible spread of infection for one (1) of two (2) residents observed for perineal care. (Resident #4).Finding include:A record review of the facility's Hand Washing policy, with a history of 9/19 revealed POLICY: Staff will use proper handwashing technique to prevent the spread of infection.A record review of the facility's Enhanced Barrier Precautions (EBP) policy, with a history of 4/24 revealed . 2. Enhanced Barrier Precautions only require use of gown/gloves when performing high contact resident.f. Changing briefs or assisting with toileting .A record review of the Enhanced Barrier Precautions (EBP) signage revealed that everyone must clean their hands, including before entering and when leaving the room. The signage further revealed that providers and staff must wear gloves and gowns for high-contact resident care activities, including changing briefs, assisting with toileting .On 9/16/25 at 4:03 PM, observed signage on Resident #4's door that revealed that Resident #4 was on Enhanced Barrier Precautions (EBP). Personal protective equipment (PPE) was observed outside of the resident's room. CNA #1 gathered supplies consisting of a brief, perineal wipes, and gloves. He entered the room with the supplies in hand and explained the care procedure to Resident #4. CNA #1 placed the brief and wipes directly on the table without a barrier in place. He applied gloves, placed the enteral feeding pump on hold, and used the bed control to adjust the bed in preparation for care. CNA #1 removed 10 perineal wipes from the pack and placed them on top of the pack on the table. He used three wipes to clean the right groin area front to back, folded the wipe, and wiped the same area again. He retrieved three additional wipes and cleaned the left groin area front to back. He then used the remaining wipes to clean the center of the vaginal area front to back one time and placed the soiled wipes on the bed. CNA #1 turned Resident #4 onto her left side to remove the soiled brief, placed the soiled brief on the bed, and applied a clean brief. CNA #1 did not wash his hands before, during, or after providing care. He did not wear a gown or change gloves during care. CNA #1 did not separate the labia to clean each side and the center individually and did not clean the rectal area. After completing care, CNA #1 removed one glove and adjusted the bed, picked up the soiled brief and gloves, disposed of them in the garbage can, removed his final glove, and exited the room without washing or sanitizing his hands.On 9/16/25 at 4:16 PM, an interview was conducted with CNA #1. CNA #1 stated he had been trained to place the feeding pump on hold during care. He confirmed that he did not wear a gown and did not wash his hands at any point during care. He confirmed that he did not perform perineal care correctly. CNA #1 stated he was nervous and forgot to follow procedure. He stated he should have had a bag for the soiled brief and acknowledged that his actions could cause Resident #4 to develop an infection.On 9/16/25 at 4:21 PM, an interview was conducted with Registered Nurse (RN) #2, Unit Manager for the B Unit. RN #2 confirmed that CNA #1 did not provide care properly and did not wear a gown before providing care. She stated CNA #1's actions constituted cross-contamination and exposed the resident to pathogens.On 9/16/25 at 5:08 PM, during an interview, the Executive Director (ED) stated she had heard about the perineal care provided by CNA #1. She stated the State Agency (SA) should have picked anyone other than him to do care. The NHA further stated all CNAs should be able to perform care correctly.On 9/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA #1 should have followed EBP guidelines by wearing a gown. She stated CNA #1 should have used a barrier for supplies and performed hand hygiene before, during, and after care. The DON stated CNA #1 should not have touched the bed controls while wearing contaminated gloves. She further stated CNA #1 should have placed the soiled brief and wipes into a clear bag instead of on the bed, changed gloves, performed hand hygiene, and applied clean gloves before performing perineal care on the buttocks area and skin folds. The DON stated EBP is implemented to protect residents and staff from infection, and CNA #1's actions placed the resident at risk for numerous infections, including urinary tract infection. She stated her expectation is that all CNAs provide quality care and follow proper procedures when providing resident care.On 9/18/25 at 8:12 AM, during a post-survey telephone interview, Registered Nurse (RN) #3, Infection Preventionist (IP), stated CNA #1 should have washed his hands before, during, and after providing care. She stated staff are trained in EBP and should wear gowns when providing care to high-risk residents. She stated CNA #1 should have followed infection control training. RN #3 stated she has conducted several in-service trainings on infection control and EBP, and that these trainings are conducted to prevent the spread of infection and are expected to be followed.A record review of Resident #4's admission Record revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia