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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winona Manor Health Care and Rehabilitation Center	627 Middleton Road Winona, MS 38967

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 52240 Based on observation, staff interview, and facility policy review, the facility failed to honor a resident's right to be treated with dignity and respect as evidenced by improper feeding practices and failure to cover biliary and urinary catheter drainage devices with privacy covers for three (3) of 93 residents residing in the facility. Resident #57, #65, and #439 The scope and severity of this deficiency was increased to E for a pattern of deficiency. This deficiency was also cited on the last annual recertification survey. Findings Include: Record review of the facility policy titled, Policies and Procedure with a revision date of 9/19/2017 revealed Subject; Catheterization, Male and Female Urinary .Foley bag to be covered by a privacy bag to preserve dignity of resident . Review of the typed statement on facility letterhead, signed by the Administrator and dated 3/27/25 revealed, (Proper name of the facility) does not have a specific policy for privacy bags for biliary drainage tubes. Resident #57 An interview with the Regional Director of Clinical Services (RDCS) on 3/27/25 at 11:04 AM revealed the facility did not have a policy related to providing dignity while assisting a resident with meals. On 3/25/25, at 12:25 PM, an observation of Resident #57 revealed Certified Nursing Assistant (CNA) #8 was standing over Resident #57 while he was in bed, feeding him his lunch meal. During an interview with CNA #8 on 3/26/25 at 11:04 AM, she confirmed that she was standing over Resident #57 feeding him. She reported that sometimes she sits to feed him but often feeds him while standing at bedside. During an interview with the Nursing Educator on 3/26/25 at 11:08 AM, she stated that Resident #57 should be fed while sitting in a chair at bedside. She stated standing over him would be a dignity issue. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission Record revealed that the facility admitted Resident #57 on 11/04/22 with a medical diagnosis that included Unspecified Sequelae of Cerebral Infarction. 48845 Resident #65 An observation on 3/25/25 at 11:05 AM revealed Resident #65 had a urinary catheter bag attached to the left side of the bed without a privacy cover and was half full of light-yellow colored urine. This observation also revealed that the resident had a biliary drain leading to a drainage bag that had a foamy, brown colored substance. Both the biliary drainage bag and the urinary catheter bag were visible from the doorway. Observation and interview on 3/26/25 at 10:07 AM with Licensed Practical Nurse (LPN) #2 confirmed that both the urinary catheter bag and the biliary drainage bag should have a privacy cover. She stated it is a dignity issue. An interview on 3/26/25 at 10:47 AM with the Assistant Director of Nursing (ADON) confirmed the urinary catheter bag and biliary drainage bags should have had a privacy cover and that it is a dignity issue. Record review of Resident #65's Admission Record revealed the facility admitted the resident on 3/9/25 with medical diagnoses that included Malignant Neoplasm of Pancreas, Unspecified. 47874 Resident #439 An observation of Resident #439 on 3/25/25 at 11:27 AM revealed he was lying in bed and had a urinary catheter drainage bag hanging on the lower bed rail that contained yellow urine and was visible from the hallway. An observation on 3/26/25 at 10:23 AM from Resident #439's doorway revealed he was lying in bed interacting with visitors. His catheter drainage bag was hanging on the lower bed rail without a privacy cover, and yellow urine was visible. An observation and interview with LPN # 3 on 3/26/25 at 10:25 AM confirmed Resident #439 did not have a privacy cover on his urinary drainage bag and stated, It's a dignity issue if they do not have a cover on their bag. Record review of the Admission Record revealed the facility readmitted Resident #439 on 3/03/25 with a medical diagnosis that included, but not limited to, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47874 Based on observation, staff interview, and facility policy review, the facility failed to provide accommodation of needs for a residents call light not being within reach for two (2) of three (3) survey days. Resident #71 Findings Include The facility provided a statement on letterhead signed by the Administrator and dated 3/27/25, (Proper name of the facility) does not have a specific policy for Call Lights. Resident #71 An observation of Resident # 71 on 3/25/25 at 11:25 AM revealed he was lying in bed. Further observation revealed his call light was hanging over a small picture on the wall, and the end of the call button was on the floor behind a bedside dresser. The resident did not have access to his call light. An observation on 3/26/25 at 10:43 AM of Resident #71 revealed he was sitting in a chair in his room. His call light was unreachable and hanging over a small picture on the wall with the end of the call button on the floor behind a beside dresser. An observation and interview with Licensed Practical Nurse (LPN) #3 on 3/26/25 at 10:47 AM revealed Resident #71 knew how to use the call light if he needed something. She confirmed the call light was unreachable. LPN #3 stated, I'm on them all the time about keeping the call lights in reach; I find them on the floor and all over the place. She confirmed anything could happen to the resident, such as falling or choking, and he would not have access to call for help. An interview with Certified Nursing Assistant (CNA) #8 on 3/26/25 at 10:55 AM confirmed Resident #71's call light should be in reach, so the resident could call staff if he required something. She revealed if the light was not in reach the resident could fall, or something could happen, and he would not be able to get help. Record review of the Admission Record revealed the facility admitted Resident #71 on 9/11/23 with a medical diagnosis that included but was not limited to Parkinson's disease with Dyskinesia.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 52240 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide a safe homelike environment as evidenced by missing air conditioner unit cover, damaged furniture, no fitted sheets and a foul odor from a stopped-up toilet for four (4) of 93 residents residing in the facility. Residents #3, #22, #28 and #47 The scope and severity of this deficiency was cited at E for a pattern of deficiency. This deficiency was also cited on the last annual recertification survey. Findings Include: Review of the facility policy titled Policies and Procedures unrevised revealed under, Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Review of the facility policy titled, Resident/Patient Room Cleaning with a revision date of 2/1/25 revealed, (Proper Name) is committed to providing a safe, clean, and hygienic environment for residents . Resident #3 On 03/25/25, at 11:00 AM, and again on 3/26/25, at 10:21 AM, an observation of Resident #3's room revealed his air conditioner/heating unit cover was on the floor. In an interview, Resident #3 voiced that staff were aware and they were looking for a clip. During an interview with Licensed Practicing Nurse (LPN) # 3, she confirmed the unit cover should not be off the unit. She stated that all maintenance repairs should be reported to the maintenance supervisor. During an interview with the Maintenance Supervisor on 3/26/25 at 10:31 AM regarding the air conditioner/heating unit cover on the floor, he reports that the staff usually contacts via text, in person, or records in the maintenance book. He reports he was unaware of the cover being on the floor in Resident #3's room. The Maintenance Supervisor confirmed the resident should have a homelike environment. Record review of the Admission Record revealed that the facility admitted Resident #3 on 11/20/23 with a medical diagnosis that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14 which indicated Resident #3 was cognitively intact. 48845 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22 An observation on 03/25/25 at 03:29 PM of Resident # 22's room revealed an approximate 18-inch section of trim with jagged, sharp edges sticking out of the top section of her dresser. An interview on 03/26/25 at 10:14 AM with Certified Nurse Assistant (CNA) #3 confirmed that Resident #22's dresser had an approximate 18-inch section of trim with jagged, sharp edges sticking out of the top section. She stated the resident could cut herself or get herself in the eye. She stated she wasn't sure how long the dresser had been in that condition. An interview on 03/26/25 10:36 AM with the Maintenance Supervisor, he stated that he was not aware of loose trim on Resident #22's dresser. He confirmed the resident could get scratched or hit her face on it. He revealed after review of the maintenance log that he was unable to find any documentation for the broken equipment. An interview on 03/26/25 at 10:47 AM with the Assistant Director of Nursing (ADON) revealed she was not aware of the loose trim on the dresser and confirmed it needed to be fixed. Record review of Resident #22's Admission Record revealed the facility admitted the resident on 9/15/22 with medical diagnoses that include Need for Assistance with Personal Care. Resident #28 An observation and interview on 03/25/25 10:45 AM for Resident # 28 revealed that the resident's approximate 18-inch auscultating fan, located at the head of the bed, had a large buildup of a gray substance on the fan blades and fan guard. The resident mentioned that she had asked for the fan to be cleaned, but it had not been done yet and that she had not been using it because it was dirty An observation and interview on 03/26/25 at 10:05 AM with the Housekeeping Supervisor confirmed that Resident #28's fan was covered in lint and dust. She stated she thinks maintenance is responsible for cleaning these type items. She stated this could cause allergies. An interview on 03/26/25 10:36 AM with the Maintenance Supervisor, he stated that the CNAs are responsible for cleaning resident's personal items. An interview on 03/26/25 at 10:47 AM with the ADON confirmed that CNAs are responsible for cleaning resident's personal items such as the fan. Record review of Resident #28's Admission Record revealed the facility admitted the resident on 7/14/22 with medical diagnoses that included Need for Assistance with Personal Care. Record review of Resident #28's MDS with an ARD of 1/27/25 revealed a BIMS score of 15, which indicates the resident is cognitively intact. 46013 Resident #47 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon entering Resident #47's room on 3/25/25 at 10:55 AM, a foul pungent smell was noted. An interview at this time with Resident #47 she stated that the toilet was not flushing and that she had told the staff about it. An observation revealed the toilet was full of a brown liquid and a brown substance that was approximately 10 inches from the top of the rim of the toilet seat. An interview on 3/25/25 at 11:00 AM, Housekeeper #1 revealed the toilet in Resident #47's room had been stopped up on and off for quite some time. She stated that they just go in and clean around the bottom of the base of the toilet and try to plunge it. She admitted that the staff report it all the time to maintenance. She revealed this had been a problem on and off for about a month and confirmed the resident's room smelled bad from the stopped-up toilet. In an interview on 3/25/25 at 11:10 AM, the Administrator (ADM) confirmed the stopped up smelly toilet was not a homelike environment and should have been taken care of. During an interview on 3/25/25 at 11:25 AM, the Maintenance Supervisor confirmed Resident #47's toilet being stopped up had been an ongoing issue and he was not sure what else to do. He revealed that they find all kinds of stuff in the toilet because they think the resident in the adjoining room has been putting wipes in the toilet. He confirmed it has been an ongoing issue. Record review of Resident #47's Admission Record revealed the facility admitted Resident #47 on 5/17/2024 with medical diagnoses which included Dementia, and Generalized Anxiety Disorder. Record review of Resident #47's MDS with an ARD of 2/14/25 revealed a BIMS score of 7 which indicated the resident had severe cognitive impairment.

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F 0656 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52240 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement a comprehensive care plan for personal hygiene (Resident #5, #12, #51), wound treatment (Resident #11), staff assistance with meals (Resident #42) and treatment for nausea and vomiting (Resident #75), for six (6) of 22 resident care plans reviewed. Findings include: Review of the facility policy titled, Plans of Care, with a revision date of 9/25/2017, revealed, An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements .Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident #5 Record review of Resident #5's Activities of Daily Living (ADL) care plan revealed .I have the potential for an ADL self-care performance deficit r/t (related to) .impaired vision and arthritis .Interventions .Diabetic nail care weekly Friday 7-3 and Bathing/Showering: Check nail length and trim and clean on bath day and as needed. Report any changes to nurse . On 3/25/25 at 11:16 AM and again on 3/26/25 at 10:25 AM an observation and interview of Resident #5 revealed gray facial hair that measured approximately one-fourth (1/4) an inch in length and his fingernails were one-eighth (1/8) inch in length, jagged with a brown substance underneath. Resident #5 stated that he needed a bath, a shave, and he would like his nails to be trimmed. An interview with Licensed Practical Nurse (LPN) # 3, she confirmed that Resident #5 had an odorous smell, and a brown substance under his long nails. LPN #3 confirmed his nails needed cleaning and cut and indicated the nurses were responsible for trimming his nails because he was a diabetic. Review of the Admission Record revealed that the facility admitted Resident #5, on 1/03/2020 with a medical diagnosis that included Type 2 Diabetes Mellitus without Complications. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 revealed under section C, a Brief Interview for Mental Status BIMS summary score of 15 which indicated Resident #5 was cognitively intact. 41878 Resident #11 Record review of Resident #11's care plan for pressure ulcer revealed intervention to administer treatments as ordered and monitor for effectiveness. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #11's Electronic Treatment Administration Record (ETAR) revealed there were 12 days in 03/2025 with missed pressure ulcer treatments documented. On 3/27/25 at 8:15 AM, an interview and record review with the Wound Care Registered Nurse (RN) confirmed the 12 undocumented wound treatments in the ETAR for Resident #11. She revealed that she worked Monday through Friday and had performed the wound treatments for this resident each day she worked but confirmed that accurate documentation was needed to verify that the care was done. On 3/27/25 at 8:10 AM, during an interview the Director of Nursing (DON) confirmed that wound treatments should be documented upon completion of the care, and this was not done for 12 of Resident #11's wound treatments for this month. She confirmed the facility failed to accurately document the wound care treatment which was a part of the wound care treatment process, so therefore, the care plan was not followed. An interview with the MDS Coordinator on 03/27/25 11:39 AM revealed she was responsible for the care plans. She confirmed the documentation was part of the treatment procedure. She confirmed the facility failed to document the treatments multiple times in the month of March for Resident #11's wound treatments, therefore the care plan was not followed. Record review of Resident #11's Admission Record revealed the facility admitted the resident on 12/7/23. Diagnoses included Pressure Ulcer of Sacral Region and Type 2 Diabetes Mellitus. Record review of MDS Section C with ARD of 2/21/25 revealed the resident was unable to participate in the BIMS as he is rarely or never understood. Resident #51 Record review of Resident #51's care plan revealed the resident had an ADL self-care performance deficit related to morbid obesity and immobility. One intervention listed was to check nail length and trim and clean on bath day and as necessary. On 3/25/25 at 11:20 AM, during an observation and interview Resident #51 revealed he wanted his toenails to be trimmed. An observation of the resident's feet revealed his big toe nail on his right foot was extending approximately three-fourths (3/4) inch from the tip of the nailbed and the left big toe nail was extending approximately one-half (1/2) inch from the tip of the nailbed. All other toenails were approximately one-third (1/3) inch long from the tips of each nailbed, jagged and uneven. On 3/26/25 at 10:25 AM, an interview and observation with the Director of Nursing (DON)confirmed that Resident #51's foot and nail care had not been done. She confirmed the facility failed to maintain the resident's toenails within a safe and comfortable length and as the resident preferred. She stated the care plan was a guide for the residents' care. She confirmed the facility failed to implement this resident's care plan for ADL's. During an interview with the MDS Coordinator on 03/27/25 at 11:39 AM, she confirmed the care plan for Resident #51's ADL care which included to check nail length and trim and clean on bath days and as necessary was not followed. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #51's Admission Record revealed the facility admitted the resident on 1/13/25. Diagnoses included Complete Lesion at T2-T6 Level of Thoracic Spinal Cord, Peripheral Vascular Disease, Lymphedema, and Need for Assistance with Personal Care. Record review of Resident #51's MDS with ARD of 3/10/25 revealed the resident had a BIMS of 13 which indicated the resident was cognitively intact. Resident #75 Record review of Resident #75's care plans initiated 2/15/24 revealed his diagnosis of gastroesophageal reflux disease (GERD) put the resident at risk for heartburn, nausea/vomiting, pain, and other gastrointestinal complications. Interventions included to give medications as ordered and observe/document/report as needed signs and symptoms of GERD including nausea/vomiting and increased gag response. Record review of the care plan for the history of an alteration in gastrointestinal status related to sigmoid colon resection revealed an intervention dated 2/15/24 to give medication as ordered. Record review of Resident #75's Order Recap Report revealed an active order for Zofran Oral Tablet 4 milligrams (mg) by PEG (percutaneous endoscopic gastrostomy) every six hours as needed for vomiting dated 3/11/24. Record review of Progress Note dated 10/20/24, revealed, Resident can't tolerate, starts gagging. Record review of Resident #75's Electronic Medication Administration Report (EMAR) revealed the as needed Zofran was not given on 10/20/24. Record review of Progress Note dated 10/28/24, revealed, Resident vomiting/gagging and can't tolerate feeding. Record review of Resident #75's EMAR revealed the as needed Zofran was not given on 10/28/24. Record review of Progress Note dated 2/22/25, revealed, Resident in bed, gave resident his med per PEG and flushes, as soon as I finished, he started vomiting his feeding, vomiting several times, feeding cut off at this time. Record review of EMAR revealed the as needed Zofran medication was not given on 2/22/25. On 3/27/25 at 9:20 AM and 10:11 AM, during interviews the DON confirmed that Resident #75 had documentation of nausea and vomiting and the ordered medication for relief of these symptoms was not administered. She stated the care plan gives the staff information for the care of each resident. She confirmed the facility failed to implement the care plan related to the administration of an ordered medication for relief or nausea/vomiting. An interview with the MDS Coordinator on 03/27/25 at 11:39 AM, confirmed the care plan for Resident #75 related to administering medications as ordered was not followed. Record review of Resident #75's Admission Record revealed the facility admitted the resident on 3/7/24. Diagnoses included Dysphagia following Cerebral Infarction, Gastrostomy Status, Gastro-esophageal Reflux Disease, and Acquired Absence of Other Specified Parts of Digestive Tract. (continued on next page)

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F 0656

Level of Harm - Actual harm

Residents Affected - Few

Record review of Resident #75's MDS Section C with an ARD of 2/27/25, revealed a BIMS of 6 which indicated the resident had severe cognitive impairment.

46013

Resident #12

A record review of Resident #12's Care Plan revealed that he had an ADL self-care deficit related to abnormal gait, lack of coordination, hx (history) of CVA (cerebrovascular vascular accident) with left sided hemiplegia, with interventions that included Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse .Personal Hygiene: I require extensive/substantial assistance of 1 staff with personal hygiene .

On 3/25/25 at 10:50 AM, an observation and interview revealed Resident #12's fingernails to be approximately one (1) inch long past the tips of the fingers, dirty in appearance, with a dark brown substance under the nail beds. Facial hair was noted on the chin and sides of the face that was approximately 1/2 (one-half) inch. Resident #12 stated, I would like to have my fingernails trimmed and would also like to be shaved.

On 3/26/25 at 10:25 AM, in an interview and observation LPN #1 confirmed Resident #12's fingernails were long, jagged, and had a brown substance under them. LPN #1 confirmed the resident needed to be shaved and should have been shaved when he received his bed bath yesterday. LPN #1 confirmed the residents' ADL care plan was not being followed and it should have been.

On 3/26/25 at 11:05 AM, during an interview the Director of Nurses (DON) confirmed the resident should have been adequately groomed, which includes shaving and nail care. The DON revealed the resident's care plan regarding his personal hygiene was not being followed, and it should have been.

A review of the Admission Record revealed the facility admitted Resident #12 on 3/3/2014 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the Left Non-Dominant Side.

Record review of Resident #12's Section C of the MDS dated [DATE] revealed a BIMS score of 11, indicating the resident has moderate cognitive impairment.

Resident #42

A record review of the Resident #42's care plan revealed I require staff assistance with ADLs related to joint pain/stiffness and impaired cognition .Interventions Eating: I am dependent on one staff to feed me my meals and snacks .

On 3/25/25 at 11:50 AM, an observation revealed Resident #42 unassisted, eating her lunch.

During an observation and interview on 3/25/25 at noon, the Assistant Director of Nurses (ADON) confirmed that Resident #42 is supposed to have a CNA (Certified Nursing Assistant) assisting her with her meals.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	An observation on 3/26/25 at 8:10 AM, revealed Resident #42 was eating her breakfast in her room unassisted. An observation on 3/26/25 at 11:50 AM, revealed Resident #42 was eating her lunch in her room unassisted. On 3/26/25 at 2:30 PM, during an interview with Registered Nurse (RN) #2, she stated, The resident is supposed to be assisted with all her meals. In an interview on 3/27/25 at 08:20 AM, the MDS Nurse confirmed that according to Resident #42's ADL care plan, she is to be assisted by a staff member for all meals, and if she wasn't being assisted with her meals by a staff member, then her plan of care was not being followed. Record review of the Admission Record revealed the facility admitted Resident #42 on 12/26/2023 with medical diagnoses that included Sequelae of Cerebral Infarction, Muscle Weakness and Need for Assistance with Personal Care. Record review of the MDS with an ARD of 12/31/2024 revealed under Section GG-Functional Abilities that the resident required Substantial/maximal assistance with eating, which details The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

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NAME OF PROVIDER OR SUPPLIER Winona Manor Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 627 Middleton Road Winona, MS 38967	

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46013

Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for three (3) of 38 sampled residents. Resident #5, #12 and #51.

The scope and severity of this deficiency was cited at E for a pattern of deficiency. This deficiency was also cited on the last annual recertification survey.

Findings include:

Review of the facility policy titled, Activities of Daily Living, dated 02/01/2022, revealed, Policy: To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, care and assistance as necessary. ADL's includes bathing, dressing, grooming hygiene, toileting and eating.

Resident #5

An observation and interview on 3/25/25 at 11:16 AM and again on 3/26/25 at 10:25 AM with Resident #5 revealed the resident had numerous visible gray facial hairs that measured approximately one-fourth (1/4) in length and his fingernails on both hands were one-eighth (1/8) inch in length past the tips of the fingers, long and uneven with some sharp edges and a brown substance underneath. During an interview for both observations Resident #5 stated that he needed a bath, shaved and he would like his nails to be trimmed.

An observation and interview with Licensed Practical Nurse (LPN) # 3, she revealed that Resident #5's fingernails were the responsibility of the nurses because he was diabetic and confirmed they needed to be cleaned and cut. She admitted that the resident had an odor, and his nails had some sort of a brown substance underneath the nail beds.

Review of the Admission Record revealed that the facility admitted Resident #5, on 1/03/2020 with a medical diagnosis that included type 2 diabetes mellitus without complications.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 revealed under section C, a Brief Interview for Mental Status BIMS summary score of 15 which indicated Resident #5 was cognitively intact.

Resident #12

An observation and interview on 3/25/25 at 10:50 AM with Resident #12 revealed all of his fingernails had a dark brown substance underneath them and were long extending approximately one (1) inch long past the tips of the fingers. The resident had approximate one-half (1/2) long facial hair covering his chin and sides of his face. The resident admitted he wanted to be shaved and have his nails cut because it had been too long.

(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/26/25 at 8:25 AM and again at 10:10 AM, Resident #12's appearance remained the same as the previous day. An interview and observation on 3/26/25 at 10:15 AM Certified Nurse Aide (CNA) #1 revealed that she gave Resident #12 a bath yesterday. She confirmed that he needed to be shaved, but he did not ask her to do it, and she did not ask if he wanted it done. She stated that she doesn't cut any of the resident's nails. She confirmed the resident's fingernails were dirty and needed cutting and admitted that the CNA's are supposed to ask the nurses if residents are diabetic, but she never has. In an interview and observation on 3/26/25 at 10:25 AM, LPN #1 confirmed that Resident #12's nails were dirty with a brown substance underneath, too long and rough. He stated the resident could cut himself with those sharp nails and possibly cause a skin infection. He revealed that the resident is a diabetic and usually the CNA's will let the nurses know when those residents need their nails trimmed. LPN #1 also confirmed the resident needed shaving and should have been shaved with his bath yesterday. During an interview on 3/26/25 at 11:05 AM, the Director of Nurses (DON) confirmed that Resident #12 and all residents should always be groomed as needed and on bath days, that includes nails and shaving. She stated that it is not the resident's responsibility to request grooming. Record review of the Admission Record revealed the facility admitted Resident #12 on 3/3/2014 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side. Record review of Resident #12's Section C of the MDS dated [DATE] revealed a BIMS score of 11, indicating the resident has moderate cognitive impairment. Resident #51 During an observation and interview on 3/25/25 at 11:20 AM with Resident #51 he stated that his toenails needed trimming. An observation of the resident's feet confirmed that all of his toenails were long and jagged extending at least 1/2 inch past the tip of the nailbed except for the right big toe. The right big toe was approximately three-fourths (3/4) inch past the nail bed. An interview with CNA #11 on 3/26/25 at 10:10 AM revealed Resident #51 was assigned to her, and it was her responsibility to trim the fingernails and toenails who were not diabetic but confirmed that she had not trimmed Resident #51's toenails. During an interview and observation with Resident #51 on 3/26/25 at 10:15 AM, LPN #1 confirmed that the resident needed his toenails tended to. She revealed that the resident is not diabetic and therefore the CNAs are responsible for trimming nails. During the observation LPN #1 stated the nails were long and jagged and should not look that way and they should have been trimmed long before now. An interview and observation with the DON on 3/26/25 at 10:25 AM, confirmed the resident's toe nails needed cut. She confirmed the facility failed to maintain the resident's toenails within a safe and comfortable length and as the resident preferred. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #51's Admission Record revealed the facility admitted the resident on 1/13/25. Diagnoses included Complete Lesion at T2-T6 Level of Thoracic Spinal Cord, Peripheral Vascular Disease, Lymphedema, and Need for Assistance with Personal Care. Record review of MDS with ARD of 3/10/25 revealed Resident #51 had a BIMS of 13 which indicated the resident was cognitively intact.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 41878 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure necessary care and services were provided for one (1) of 38 residents (Resident #75) reviewed for PEG (percutaneous endoscopic gastrostomy) tube management and PRN (as needed) medication administration. Specifically, nursing staff failed to administer Zofran 4 mg (milligrams) PRN for vomiting/gagging on multiple documented occasions, despite physician orders and clinical indications. This failure resulted in Resident #75 experiencing vomiting and feeding intolerance, requiring cessation of tube feeding, and caused unnecessary discomfort. Findings include: Record review of the facility policy titled, Enteral Feedings - Enteral Nutrition Pump, with revision date of 11/12/18, revealed, Nurses administer enteral feedings when volume control is indicated and as ordered by physician. Record review of facility policy titled, Administering Medication, dated 4/19, revealed, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame . During the initial tour on 3/25/25 at 11:05 AM, an observation revealed Resident #75 lying in bed awake, alert and responsive, but not interviewable. He had a tube feeding of Glucerna 1.5 infusing by feeding pump at 50 milliliters per hour. Record review of Progress Note dated 10/20/24, revealed, Resident can't tolerate, starts gagging. Record review of Resident #75's Order Recap Report revealed an active order for Zofran Oral Tablet 4 milligrams (mg) via PEG (percutaneous endoscopic gastrostomy) tube every six hours as needed for vomiting dated 3/11/24. Record review of Resident #75's Electronic Medication Administration Report (EMAR) revealed the as needed Zofran was not given on 10/20/24. Record review of Progress Note dated 10/28/24, revealed, Resident vomiting/gagging and can't tolerate feeding. Record review of Resident #75's EMAR revealed the as needed Zofran was not given on 10/28/24. Record review of Progress Note dated 2/22/25, revealed, Resident in bed, gave resident his med per PEG and flushes, as soon as I finished, he started vomiting his feeding, vomited several times, feeding cut off at this time. Record review of EMAR revealed the as needed Zofran medication was not given on 2/22/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/27/25 at 8:44 AM, the Regional Director of Clinical Services stated Resident #75 had nausea and vomiting and was not given an ordered medication for the relief of the vomiting. She confirmed the facility failed to administer an ordered medication to a resident with nausea/vomiting to decrease his discomfort. During interviews on 3/27/25 at 9:20 AM and 10:11 AM, the Director of Nursing (DON) stated the review of the documentation on 10/20/24, 10/28/24, and 2/22/25 revealed the resident was gagging with vomiting and he did not receive the ordered medication for nausea relief. She confirmed the facility failed to administer an ordered medication to a resident with nausea and vomiting. Record review of Resident #75's Admission Record revealed the facility admitted the resident on 3/7/24. Diagnoses included dysphagia following cerebral infarction, gastrostomy status, gastro-esophageal reflux disease, and acquired absence of other specified parts of digestive tract. Record review of Resident #75's Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 2/27/25, revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment.

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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. 47874 Based on observation, staff interview, and record review the facility failed to ensure there was a physician's order and provide catheter care to a resident with an indwelling catheter for one (1) of eight (8) residents with an indwelling catheter reviewed. Resident #439 Findings Include: Review of the facility provided statement on letterhead dated 3/27/25 and signed by the Administrator revealed, (Proper name of the facility) does not have a specific policy for obtaining physician orders. An observation of Resident #439 on 3/25/25 at 11:27 AM revealed he was lying in bed. His catheter drainage bag was hanging on the lower bed rail, with yellow urine visible from the hallway. Record review of Resident #439's Order Summary Report with active orders as of 3/26/25 revealed the resident did not have an order for the urinary catheter or catheter care orders. An interview with Licensed Practical Nurse (LPN) #3 on 3/26/25 at 2:58 PM, she indicated Resident #439 returned from the hospital on 3/21/25 with an indwelling catheter. She confirmed the resident did not have any physician orders related to the catheter. LPN #3 revealed the admitting nurse on 3/21/25 should have done a hospital return assessment and ensured the orders were put into the system. LPN #3 further indicated the facility had a stand-up meeting every day to ensure all the new orders were captured and corrected from any admissions. She confirmed the resident would not get the proper catheter care and monitoring without orders in place. Record review of Resident #439's Progress Notes dated 3/21/25 revealed, Catheter is indwelling. Record review of the Admission Record revealed the facility readmitted Resident #439 on 3/03/25 with a medical diagnosis that included, but not limited to, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side. An interview with the Minimum Data Set (MDS) Nurse on 3/26/25 at 3:06 PM revealed that when Resident #439 came back from the hospital on 3/21/25, his discharge paperwork did not mention that he had a catheter. She revealed the admitting nurse would have been responsible for contacting the physician to obtain orders. She confirmed that without the orders in place, the resident would not get the proper catheter care needed and proper monitoring for complications.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47157 Based on observations, staff interviews, and facility policy review, the facility failed to ensure that staff received adequate education and training regarding the use and implementation of Enhanced Barrier Precautions (EBP). As a result, staff did not utilize the required personal protective equipment (PPE) during four (4) high-contact resident care activities observed, potentially putting all residents residing in the facility at risk for the spread of multidrug-resistant organisms (MDROs). Findings include: cross-reference F 880 Review of the facility policy titled, Enhanced Barrier Precautions, with an effective date of 9/01/22, revealed the following: Policy: Enhanced barrier precautions (EBP) are used to reduce the spread of multidrug-resistant organisms (MDROs) among residents by utilizing gloves and gowns for high-contact resident care activities. Procedure: 4.) Educate the staff on EBP, including but not limited to: a.) use of PPE (personal protective equipment) . b.) High-contact care areas . During observations of four (4) high-contact resident care activities, staff were not observed at any time using EBP for Residents #11, # 25, # 32, and #75. On 3/26/25 at 8:00 AM, an observation of Resident #75 during medication pass revealed Licensed Practical Nurse (LPN) #4 administered the resident's medications via PEG (percutaneous endoscopic gastrostomy) tube without wearing a gown for EBP. On 3/26/25 at 10:35 AM, during an observation the Wound Care Registered Nurse (RN), assisted by Certified Nursing Assistant (CNA) #5, provided wound care for Resident #11. Neither staff used enhanced barrier precautions (EBP) during the wound care procedure. On 3/26/25 at 11:50, during an observation of wound care for Resident #32 AM with the Wound Care Nurse and CNA #5 there was no observation of the wound care nurse or CNA #5 applying a gown as part of the EBP. On 3/26/25 at 12:15 PM, an observation of Resident #25's wound care with the Wound Care Nurse assisted by CNA #5 revealed that the care was provided without using a gown for EBP. During an interview with the Wound Care Nurse and Certified Nurse Assistant (CNA) #5 on 3/26/25 at 12:22 PM, they confirmed they had not been in-serviced or trained on EBP. During an interview with the Corporate Nurse on 3/26/25 at 12:30 PM, she confirmed that staff had not been educated, and the precautions had not been implemented. During an interview with CNA #6 on 3/26/25 at 1:25 PM, she confirmed she had not been trained or had knowledge of EBP or its purpose. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Infection Control Nurse on 3/26/25 at 2:51 PM, she revealed that she was aware of what EBP was because she learned it in her infection control (IC) training. She also confirmed she had never received any education in the facility related to EBP and was unaware of why the facility had not educated staff or implemented the EBP practice. During an interview with the Administrator on 3/26/25 at 3:00 PM, he revealed he was not aware that staff were not using EBP. He stated that the facility had been using EBP at one point but experienced a breakdown in its practice due to significant staff turnover in the past six months. During an interview with the Staff Educator on 03/27/25 at 10:30 AM, she revealed she had been in her position since July of 2024 and conducts skill competencies for staff and new hires. She confirmed that EBP was not part of the education provided and stated that since her hire date, there had been no education on EBP for any staff. She also stated she was unable to locate any education on EBP prior to her hire date. During an interview with Licensed Practical Nurse (LPN) #1 on 3/27/25 at 10:41 AM, he revealed he had been employed for over a year and confirmed he did not know what EBP was and had never been educated on it. During an interview with CNA #9, on 3/27/25 at 10:44 AM, she confirmed she had been employed at the facility for a year. She confirmed she had never been educated on EBP and did not know what it was. During a follow-up interview with the Administrator on 3/27/25 at 10:48 AM, he confirmed that, due to staff not being educated on EBP and the lack of documented proof of education, the facility had failed to ensure staff had the knowledge necessary to understand and implement EBP. He stated that the concern resulting from failing to educate the staff on EBP was that high-risk residents would not receive the precautions they needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48845 Based on observation, resident/staff interview and record review, the facility failed to ensure a resident's medications were not left unattended in the resident's room for one (1) of 38 sampled residents. Resident #28. The scope/severity for this deficiency was increased to E due to previous citation on the last annual recertification survey. Findings include: Record review of a statement on the facility's letterhead dated 3/27/25 and signed by the Administrator revealed, (Proper name of the facility) does not have a specific policy for unattended medication. During an observation and interview on 3/25/25 at 10:45 AM, a small bag of intravenous (IV) fluids with a vial of medication attached to the bag was observed from the open doorway, lying on Resident #28's bedside table. The resident confirmed it was her antibiotic medication, and the nurse needed to restart her peripheral IV before administering it. During an observation on 3/25/25 at 1:37 PM with Registered Nurse (RN) #1, confirmed the presence of the IV antibiotic medication on the bedside table. RN #1 acknowledged that the medication should not have been left unattended, as another resident might have accessed it with the door open to the hallway. During an interview on 3/25/25 at 2:30 PM with the RN Supervisor confirmed that leaving the IV medication unattended was inappropriate and that it posed a risk of access by another resident. During an interview on 3/26/25 at 10:47 AM with the Assistant Director of Nursing (ADON) confirmed the medication should not have been left on the bedside table. A record review of the Admission Record for Resident #28 revealed that she was admitted to the facility on [DATE] with a diagnosis of polyneuropathy, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #28 is cognitively intact.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 46013 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide a resident with adaptive equipment and staff assistance for three (3) of three (3) dining observations. Resident #42 Findings include: Review of the facility policy titled Assistive Devices with a revision date of 10/2022 revealed under, Policy Statement .Assistive devices/utensils will be provided as identified in the individualized plan of care to maintain or improve a resident's/patient's ability to eat or drink independently. An observation on 3/25/25 at 11:50 AM revealed Resident #42 unassisted, eating her lunch; her meal was on a regular plate, and the resident was struggling with holding her spoon. No adaptive utensil equipment was noted. During an observation and interview on 3/25/25 at 12:00 PM, the Assistant Director of Nurses (ADON) confirmed that Resident #42 did not have her divided plate and stated that it was on her meal ticket to have one, and the resident is supposed to have a Certified Nurse Aide (CNA) assisting her with her meals also. On 3/26/25 at 8:10 AM, an observation revealed Resident #42 eating her breakfast in her room unassisted with no adaptive utensils were noted. On 3/26/25 at 11:50 AM, an observation revealed Resident #42 eating her lunch in her room unassisted with no adaptive utensils noted. During an observation and interview on 3/26/25 at 12:00 PM, CNA #10 stated, I'm new, and I'm not sure if the resident requires assistance with eating. An interview on 3/26/25 at 2:30 PM, Registered Nurse (RN) #2 stated, The resident is supposed to be assisted with all her meals, and she uses big utensils and a divided plate also. In an interview on 03/26/25 at 2:40 PM, the Occupational Therapist (OT) revealed she was aware that the resident required a divided plate and revealed when the resident was discharged from occupational therapy last month, she had recommended for her to use adaptive built-up utensils to assist the resident in holding her spoon or fork in addition to using her divided plate. Record review of the Physicians Orders revealed no order for the built-up utensils or the divided plate. Record review of the Admission Record revealed the facility admitted Resident #42 on 12/26/2023 with medical diagnoses that included sequelae of Cerebral Infarction, muscle weakness and need for assistance with personal care. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 12/31/2024 revealed under Section GG-Functional Abilities that the resident required Substantial/maximal assistance with eating, which details The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41878 Based on staff interviews, record review, and facility policy review, the facility failed to document if wound treatments had been completed for a resident with a Stage 4 pressure ulcer for one (1) of three (3) residents with wounds reviewed. Resident #11 Findings include: Record review of facility policy titled, Dressing Change, dated 12/6/17, revealed, A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Document in medical record. Record review of Order Listing Report revealed an order dated 2/21/25 for wound care to stage four pressure ulcer to sacral region to clean with one-quarter (1/4) strength Dakins, pat dry with 4x4 gauze, apply collagen with silver sheet, cover with bordered dry dressing daily until healed every day shift. This order was discontinued on 3/25/25. Record review of Electronic Treatment Administration Record (ETAR) for March 2025 revealed wound treatments for 3/1/25, 3/4/25, 3/5/25, 3/6/25, 3/7/25, 3/12/25, 3/13/25, 3/14/25, 3/16/25, 3/18/25, 3/24/25, and 3/25/25 were not documented as administered. An interview and record review with the Wound Care Registered Nurse on 3/27/25 at 8:15 AM, revealed she worked Monday through Friday and had performed the wound treatments for Resident #11 each day she worked. A record review with the Wound Care RN confirmed there were 12 undocumented treatments in the electronic treatment administration record (ETAR) for this month. She stated she thought that she always documented her care but admitted she missed documenting multiple treatments. She stated it might be due to how it was put into the computer, behind multiple respiratory entries and she failed to see it. She stated accurate documentation was needed to verify that the care was done on each resident's record. During an interview on 3/27/25 at 8:10 AM, the Director of Nursing (DON) confirmed that wound treatments should be documented upon completion of the care, and this was not done for 12 of Resident #11's wound treatments for this month. She stated that documenting care is part of the continuity of care and treatment. She verified that treatments should be done and documented accurately. Record review of Resident #11's Admission Record revealed the facility admitted the resident on 12/7/23. Diagnoses included Pressure Ulcer to Sacral Region and Type 2 Diabetes Mellitus. Record review of Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 2/21/25 revealed that Resident #11 was rarely or never understood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winona Manor Health Care and Rehabilitation Center	627 Middleton Road Winona, MS 38967

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41878

Based on observations, staff interviews, record reviews, and policy review, the facility failed to implement and maintain an effective Infection Prevention and Control Program (IPCP) for five (5) of thirty-eight (38) sampled residents (Residents #11, #25, #32, #65, and #75). Specifically, the facility failed to ensure staff used Enhanced Barrier Precautions (EBP) during high-contact resident care activities (wound care and percutaneous endoscopic gastrostomy (PEG) tube handling), failed to prevent the reuse of a single-use medical device (PEG tube declogger), and failed to store a biliary drainage collection bag in a sanitary manner. These failures created an increased risk for the transmission of infectious organisms among residents requiring complex care.

Findings include:

Cross- reference F726

Review of the facility policy titled Infection Prevention and Control Program with a revision date of 10/2018 revealed under, Policy Statement: An infection prevention and control program (IPCP) Is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Review of the facility policy titled, Enhanced Barrier Precautions, with an effective date of 9/01/22, revealed the following: Policy: Enhanced barrier precautions (EBP) is used to reduce the spread of Multidrug-resistant organisms (MDROs) among residents by utilizing gloves and gowns for high-contact resident care activities . High-contact care activities provide opportunities for the transfer of MDROs to staff hands and clothing . High-contact care activities include: feeding tube care, wound care .

Record review of facility's letterhead revealed, This facility does not have a policy on storage of a biliary tube bag.

Resident #11

During an observation and interview on 3/26/25 at 10:35 AM, the Wound Care Registered Nurse (RN) and Certified Nursing Assistant (CNA) #5 performed wound care for Resident #11. The RN performed the wound treatment on the resident's sacral area and CNA #5 assisted. Neither staff used enhanced barrier precautions (EBP) during the wound care procedure.

During an interview on 3/27/25 at 8:15 AM, the Wound Care RN revealed she was unaware of the EBP guidelines and did not dress out during her wound care treatments. She stated she had now been in-serviced on EBP and the purpose to decrease the risk for infection.

Record review of Resident #11's Admission Record revealed the facility admitted the resident on 12/7/23. Diagnoses included pressure ulcer to sacral region and type 2 diabetes mellitus.

Record review of Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 2/21/25 revealed the resident was rarely or never understood.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	47874 Resident #25 Record review of Resident #25's Order Listing Report revealed an order dated 12/27/24, Cleanse unstageable pressure ulcer to tip of left great toe with wound cleanser or NS (normal saline), pat dry with 4 x 4 gauze, paint with betadine and cover with bordered gauze dressing q (every) Monday, Wednesday and Friday. An observation of Resident #25's wound care with the Wound Care Nurse assisted by CNA #5 on 3/26/25 at 12:15 PM revealed that the care was provided without using a gown for EBP. An interview with both the Wound Care Nurse and CNA #5 on 3/26/25 at 12:20 PM confirmed they did not dress out in a gown for EBP during Resident #25's wound care. They both revealed they had no knowledge of these precautions and indicated they had not been in-serviced or had any training on the subject. An interview on 3/26/25 at 12:25 PM with CNA #2 and CNA #6 confirmed neither had been trained nor had knowledge of EBP. An interview with the Regional Director of Clinical Services (RDCS) on 3/26/24 at 12:30 PM revealed the facility was currently working on getting EBP into place and confirmed staff had not been educated, and the precautions had not been practiced at the facility. She confirmed the purpose of using EBP was to protect the residents from infection. Record review of the Admission Record revealed the facility admitted Resident #25 on 9/15/23 with a medical diagnosis that included metabolic encephalopathy. Resident #75 An observation of Resident #75 during medication administration on 3/26/25 at 8:00 AM revealed Licensed Practical Nurse (LPN) #4 attempted to flush the resident's PEG tube with water, but the tube was clogged. LPN #4 retrieved an opened package off the bedside table and indicated it was a peg tube declogger. The opened package was undated, and she inserted the declogger inside the resident's peg tube multiple times. Afterward, she rinsed the de-clogger and placed it back into the package. She administered the resident's medications via PEG tube without wearing a gown for EBP. Review of the Bionix Enteral Feeding Tube Declogger manufacturer's instructions online revealed single use and discard after using. An interview with LPN #4 on 3/26/25 at 8:47 AM confirmed the manufacturer's instructions revealed the tube declogger was for single use and revealed reusing the declogger placed Resident #75 at risk for infection. LPN #4 confirmed she did not wear a gown to administer the medications and indicated she had not been trained or had any in-services on using EBP. On 3/26/25 at 3:21 PM, an interview with the RDCS with the Director of Nursing (DON) in attendance revealed the staff should not be using feeding tube de-cloggers and voiced there were other alternatives to handle a clogged tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Admission Record revealed the facility admitted Resident #75 on 3/07/24 with medical diagnoses that included sequelae of cerebral infarction and gastrostomy status. 47157 Resident # 32 During an observation of wound care for Resident #32 on 3/26/25 at 11:50 AM with the Wound Care Nurse and CNA #5, revealed the Wound Care Nurse or CNA #5 did not don a gown as part of the EBP. A review of the March 2025 Treatment Record for Resident #32 revealed the following: Clean diabetic/PVD (peripheral vascular disease) right heel wound with wound cleanser, pat dry, apply collagen dressing with silver, cover with kerlix and secure with tape daily, signed off as completed on 3/26/25. During an interview with the Wound Care Nurse and CNA #5 on 3/26/25 at 12:22 PM, it was confirmed that they did not wear any special PPE for EBP during Resident #32's wound care and that they had not been in-serviced or trained on EBP. A review of Resident #32's Admission Record revealed that he was admitted on [DATE], with a diagnosis of Type II diabetes. During an interview with the Infection Control (IC) Nurse on 3/26/25 at 2:51 PM, she revealed that she was aware of what EBP was because she learned about it in her Infection Control training. She stated that EBP is used as an extra layer of protection between residents and staff to reduce the spread of infection for residents with open wounds and indwelling devices. She confirmed that the facility was not using EBP for any residents. She also revealed she was unaware of why the facility did not educate staff or implement EBP practice. During an interview with the Administrator on 3/26/25 at 3:00 PM, he revealed that he was not aware staff were not using EBP. He stated that the facility had been using EBP at one point but experienced a breakdown in its practice due to significant staff turnover in the past six months. During a follow-up interview with the Administrator on 3/27/25 at 10:48 AM, he confirmed that concerns from failing to educate and implement EBP is that high-risk residents would not receive the necessary precautions. 48845 Resident # 65 During an observation on 3/25/25 at 11:05 AM of Resident #65 revealed he was lying in bed with a biliary drain connected to a drainage bag. The biliary drainage collection bag with a brown, foamy substance was lying on the floor visible from the doorway. During an observation and interview on 3/26/25 at 10:07 AM with LPN) #2, it was confirmed the biliary drainage collection bag should not be on the floor. She further confirmed that the bag being on the floor was an infection control issue. She stated, the floor is the nastiest place! (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/25 at 10:47 AM with the Assistant Director of Nursing (ADON) it was confirmed the that the biliary drainage collection bag should not have been on the floor as that is an infection control concern that could lead to an infection to the resident. Record review of Order Summary Report confirmed Resident #65 had orders related to a biliary drain with start date 2/28/25. Record review of Admission Record revealed the facility admitted Resident #65 on 3/9/25 with medical diagnoses that included Malignant Neoplasm of Pancreas, and Obstruction of Bile Duct.