STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255173	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Trace Health and Rehabilitation	555 John R. Junkin Drive Natchez, MS 39120

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, facility policy review and interviews, the facility failed to provide necessary treatment and services to promote the healing of a pressure ulcer and prevent infection for one (1) of three (3) sampled residents with pressure injuries. Resident #3Findings Included:Record review of the facility policy titled, Pressure Injury Prevention and Management with a review/revision date of 11/07/25 revealed, This facility is committed to the prevention of avoidable pressure injuries.and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .Record review of the facility policy titled, Clean Dressing Change with a review/revision date of 11/0725 revealed, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and /or cross-contamination.12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. (that is) clean outward from the center of the wound) .Record review of the Care Profile under the clinical section revealed orders for Resident #3 dated 12/12/2025 to Cleanse pressure ulcer to right lateral foot with wound cleaner, pat dry, apply wet to dry betadine dressing, apply border gauze, wrap with kerlix and secure with tape with a start date of 11/25/25; an order Cleanse area to right heel with wound cleaner, pat dry apply wet to dry betadine dressing, apply border gauze, wrap with kerlix and secure with tape. Once daily and prn (as needed) one time a day related to PRESSURE ULCER OF RIGHT HEEL, UNSTAGEABLE with a start date of 12/13/25 and discontinue date of 3/18/26. An additional order with a start date of 12/13/25 revealed Cleanse area to left heel with wound cleaner, pat dry, and apply border gauze once daily and prn (as needed) one time a day related to PRESSURE ULCER OF LEFT HEEL, UNSTAGEABLE. On 3/31/26 at 12:40 PM, during an observation revealed that as Registered Nurse (RN) #1 provided wound care to the open pressure sore on the right ankle and heel of Resident #3, she wiped the dime sized open area over Resident #3's right ankle four times from above the open wound to below it (directionally toe to heel) with gauze wet with wound cleanser, then disposed of the gauze, obtained a clean wet (with wound cleaner) gauze and wiped four times from above the open area to below the wound with the same surface of the wet gauze. RN #1 provided wound care to the pressure sore on the left ankle of Resident #3 without gown, and wiped the open wound four times from above the open wound to below it (directionally toe towards heel) with gauze wet with wound cleanser, then disposed of the gauze, got a clean wet (with wound cleaner) gauze and wiped twice with the same surface of the wet gauze. Record review of the March 2026 Treatment Administration Record (TAR) revealed documentation that RN #1 had provided treatment for the pressure ulcer to right lateral foot, and the area to right heel, left heel on 3/31/26. Documentation indicated treatment was provided by RN #1 on 3/31/26. On 4/01/26 at 11:10 AM, during an interview the Director of Nurses (DON) revealed she expected the nurses to provide all wound care in a manner according to current standards of infection control and prevention, which she said included cleaning away from any areas of open wounds and using clean surfaces of cleaning material such as gauze for each contact with open areas/wounds. On 4/01/26 at 12:12 PM, during an interview and record review the Staff Development Coordinator stated that she provided staff with in-service training monthly and as needed, and provided orientation training with newly hired nursing staff, Certified Nursing Assistants (CNAs) and nurses. She stated that hand (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene competency checkoffs were required for nurses' staff during their orientation, prior to working directly with residents. She stated that RN #1 had completed competency checkoff for wound care on 3/31/26. Record review of the Validation Checklist Wound Care dated 3/31/26, signed by RN #1 and the Staff Development Coordinator revealed the Procedure included Cleansed wound thoroughly with prescribed cleansing agent, taking care to not contaminate other skin surfaces or other surfaces of the wound.On 4/01/26 at 1:00 PM, during an interview, RN #1 revealed that Resident #3 had a pressure ulcer on each of his outer ankles. She stated that she had wiped over the open area of the pressure ulcers on both of Resident #3's ankles multiple times with the same side of the same wet gauze because she was trying to remove something like discharge or slough that she observed at the open wound site and said, that's just me, then asked State Agency (SA) what was the correct way to clean a wound. She stated she was not aware of facility wound care protocols. She stated that the facility did not provide a protocol to follow.On 4/01/26 at 4:30 PM, during an interview the Administrator revealed he expected the nurses to provide care, including pressure sore treatments in a manner to prevent infections.Record review of the admission Record for Resident #3 revealed the facility admitted the resident on 8/05/25 and the resident had diagnoses of aphasia, dysphagia, cerebral infarction (stroke), PRESSURE ULCER (PU) OF LEFT HEEL, UNSTAGEABLE, PRESSURE ULCER OF RIGHT HEEL, UNSTAGEABLE, both added to diagnosis information on 12/12/25 and PRESSURE ULCER OF RIGHT ANKLE, UNSTAGEABLE added to diagnosis information on 12/5/2025.Record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/26 for Resident #3 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate 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. Based on observation, interview, record review, and facility policy review the facility failed to ensure staff provided incontinent care using proper infection control techniques for one (1) of six (6) sampled residents. Resident #3. Findings Included:Record review of the facility policy titled, Incontinence with a review/revision date of 11/07/25 revealed, .4. Residents that are incontinence of bladder or bowel will receive appropriate treatment to prevent infections.Record review of the Skill Competency Assessment: Perineal Care dated 6/19/25 and signed by Certified Nursing Assistant (CNA) #1 revealed, . Male Resident.b) Wash penis with peri wash (add directly to wash cloth), soap and water or disposable peri-wipes, moving in a circular motion form the tip of the penis using downward strokes.c) Using a fresh wash cloth clean and rinse the scrotal area. 10. Clean anal area with peri-wash and clean washcloth or disposable peri wipes, using front to back strokes without contaminating perineal area.On 3/31/26 at 12:15 PM, during an observation revealed during incontinent care, CNA #1 took three premoistened disposable wipes and wiped Resident #3's penis and anterior (front) perineal area front to back resulting in visual discoloration of the wipes and then wiped back and forth three (3) more times without changing sides of the wipes or changing wipes with the soiled wipes. CNA #1 then discarded the soiled wipes, got three more premoistened disposable wipes and wiped Resident #3's rectal area back and forth (3) times and then wiped his scrotum with the same wipes.On 3/31/26 at 12:25 PM, during an interview CNA #1 that she did not verbally respond when asked if she was aware of the correct procedure or facility protocol for incontinence care.Record review of the Kardex Report dated 4/01/26 for Resident #3 revealed Resident care interventions for Resident #3 included .Toileting Hygiene: Helper is doing all of the task.Bed Mobility Rolling Left and Right: Helper performs more than 50% (fifty percent) of the task.Toilet Transfer: Not attempted d/t (due to) medical condition.Toileting: Clean peri area with each incontinence episode. On 4/01/26 at 11:10 AM, during an interview the Director of Nurses (DON) stated she expected the nurses to supervise the care of residents and she expected the CNA s to provide incontinence care in a manner that would prevent infection, including wiping only front to back (1) time with clean surface of the cleaning cloth (washcloth or premoistened disposable wipe) and then ensuring each wipe was accomplished with a clean surface. She confirmed that wiping back and forth multiple times with soiled cleaning surface could lead to urinary tract infection.On 4/01/26 at 12:12 PM, during an interview the Staff Development Coordinator stated that she provided staff with in-service training monthly and as needed, and provided orientation training with newly hired nursing staff, CNAs and nurses. She explained that competency checkoffs on incontinence care procedures were required for all CNAs during their first (90) days of employment at the facility and that CNA #1 had successfully completed competency checkoff on 6/19/25. She said competencies were repeated annually.On 4/01/26 at 4:30 PM, during an interview the Administrator revealed he expected the nurses to supervise the care of the residents and that incontinent residents would receive care in a manner to prevent infections.Record review of the admission Record for Resident #3 revealed the facility admitted the resident on 8/05/25 and the resident had diagnoses of aphasia, dysphagia, cerebral infarction (stroke), PRESSURE ULCER (PU) OF LEFT HEEL, UNSTAGEABLE, PRESSURE ULCER OF RIGHT HEEL, UNSTAGEABLE, both added to diagnosis information on 12/12/25.Record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/26 for Resident #3 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment and that the resident had four (4) pressure ulcers at the time of the assessment.

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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. Based on observation, record review, facility policy review and interviews, the facility failed to prevent the potential for spread of infections as evidenced by not implementing Enhanced Barrier Precautions (EBP) during wound care for one (1) of three (3) sampled residents with pressure injuries. Resident #3Findings Included:Record review of the facility policy titled, Pressure Injury Prevention and Management with a review/revision date of 11/07/25 revealed, This facility is committed to the prevention of avoidable pressure injuries.and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .Record review of the facility policy titled, Clean Dressing Change with a review/revision date of 11/0725 revealed, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and /or cross-contamination.Record review of the Care Profile revealed an order dated 1/20/26 for EBP- r/t (related to) wounds. On 3/31/26 at 12:40 PM, observation revealed that as Registered Nurse (RN) #1 provided wound care to the open pressure sore on the right ankle and heel and pressure area on the left ankle without donning (putting on) a gown. On 4/01/26 at 11:10 AM, during an interview the Director of Nurses (DON) revealed she expected the nurses to be provide all wound care in a manner according to current standards of infection control and prevention, She confirmed that the facility had an ample supply of all personal protective equipment (PPE) required for care of residents on EBP and she expected staff to use the appropriate PPE for direct care.On 4/01/26 at 12:12 PM, during an interview the Staff Development Coordinator stated that she provided staff with in-service training monthly and as needed and provided orientation training with newly hired nursing staff. She stated that hand hygiene and PPE competency checkoffs were required for nurses' staff during their orientation, prior to working directly with residents. She stated that RN #1 had completed competency checkoff for wound care on 3/31/26.On 4/01/26 at 1:00 PM, during an interview Registered Nurse (RN) #1 revealed that Resident #3 had a pressure ulcer on each of his outer ankles and that EBP were in place for direct contact care for Resident #3. She stated that she was not aware of the requirements for direct care of residents with open wounds or EBP. She confirmed that Resident #3 had printed signage posted on the door with a list and pictures of necessary PPE needed, a list of interactions that required the PPE and that she had not worn a gown for wound care provided for Resident #3 on 3/31/26. On 4/01/26 at 4:30 PM, during an interview the Administrator revealed he expected the nurses to provide care, including pressure sore treatments in a manner to prevent infections.Record review of the admission Record for Resident #3 revealed the facility admitted the resident on 8/05/25 and the resident had diagnoses of aphasia, dysphagia, cerebral infarction (stroke), PRESSURE ULCER (PU) OF LEFT HEEL, UNSTAGEABLE, PRESSURE ULCER OF RIGHT HEEL, UNSTAGEABLE, both added to diagnosis information on 12/12/25 and PRESSURE ULCER OF RIGHT ANKLE, UNSTAGEABLE added to diagnosis information on 12/5/2025.Record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment and that the resident had four (4) pressure ulcers at the time of the assessment.