STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255206	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Health and Rehabilitation	310 Emerald Drive Columbus, MS 39702

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility policy review, the facility failed to maintain food service areas in a sanitary manner to prevent the potential for food contamination. Specifically, the facility failed to ensure ventilation ductwork was free from a black mold-like substance in areas located above food preparation and food storage locations on two (2) of (2) kitchen tours. Findings include:Review of facility policy titled Sanitation and Infection Control with no date, revealed, Standard: .to ensure sanitary conditions.in the dining service department.On 1/20/2026 at 10:21 AM, during an initial tour of the facility kitchen accompanied by the Dietary Manager revealed an observation of a black mold-like substance on the ventilation ductwork above the stove, with visible dark discoloration along the seams and underside of the duct. A similar black mold-like substance was also observed on the ductwork in the dry storage room, extending along multiple sections of the duct. Both locations were in close proximity to food preparation and food storage areas. The Dietary Manager confirmed the substance had been present for several months.During an observation of the ductwork in the kitchen on 1/20/2026 at 11:38 AM, with the Plant Operations Manager, he confirmed the presence of a black mold-like substance on the ductwork above the stove and food preparation areas and on the ductwork in dry storage room, which he stated increased the risk for food contamination.During an interview with the Administrator on 1/20/2026 at 3:30 PM, she confirmed there was a risk for foodborne illness related to the presence of the black mold-like substance above the stove and food preparation areas.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's wheelchair was maintained in a safe manner for one (1) of 68 residents requiring a standard wheelchair for locomotion. Resident #12 Findings Include:Review of the facility policy titled Preventative Maintenance for Wheelchairs undated, revealed under, Policy: It is the practice of this facility to develop and implement a preventative maintenance program to ensure wheelchairs are maintained in a safe and operable manner. Also revealed under, Policy Explanation and Compliance Guidelines: . 4. Preventative maintenance should be performed weekly or as indicated: . e. Check seats, backs, arm rest and cushions for tears, cracks or missing screws-replace or repair if present.An observation and interview on 1/20/26 at 11:10 AM, revealed Resident #12 seated in her wheelchair with significant damage to both armrests. Each armrest was split in half, exposing the hard gray plastic interior. The black vinyl armrest covering was torn and hanging loosely from the sides, and a protruding silver screw was visibly present on the right armrest. The resident's arms were resting directly on the exposed plastic. She stated staff knew about the condition of the wheelchair and that the chair had been like that for a while.An observation and interview with the Administrator on 1/21/26 at 3:53 PM, revealed her expectations were for residents to have safe, operating equipment in good repair. She explained that aides were responsible for reporting broken or damaged equipment in the maintenance log so repairs could be made. The Administrator confirmed Resident #12 had broken wheelchair armrests in poor condition which could cause skin concerns.Record review of the admission Record revealed the facility admitted Resident #12 on 8/12/24 with diagnoses that included Schizoaffective Disorder, Bipolar Type, and Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #12 was cognitively intact.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review and facility policy review the facility failed to implement a comprehensive care plan related to applying a hand splint (Resident #61) and nail care (Resident #66, and #89) for three (3) of twenty four care plans reviewed. Findings include: Review of the facility care plan policy titled, Comprehensive Care Plan with a revision date of 4/2025, revealed It is the standard of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #66 Record review of Resident #66's Care Plan Report revealed Focus: (Proper name of Resident #66) has an ADL (Activities of Daily Living) self care performance deficit r/t (related to) increased weakness and limited mobility. Listed under Interventions/Tasks was Personal Hygiene/oral care: He requires set up and clean up assistance from 1 (one) staff to complete personal hygiene and oral care. During an interview and observation on 1/20/26 at 12:40 PM, Resident #66 revealed he liked his nails kept short and smooth and would like for them to be trimmed. Nails were observed to be approximately 1/4 inch from nail bed with a brown substance under several nails noted. Nails were jagged and rough in multiple areas. On 1/21/26 at 3:50 PM, during an interview and observation, the Director of Nursing revealed her expectation was for each dependent resident to receive personal hygiene which included nail care and acknowledged that Resident #66's nails were long, dirty, and jagged. She confirmed the facility failed to maintain a resident's nails at an appropriate and safe length and in clean condition and therefore did not follow the care plan for assistance with activities of daily living care. During an interview on 1/22/26 at 10:20 AM, the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator revealed the purpose of the care plan was to inform the staff of the needs of the residents so these needs could be met. She acknowledged that nail care was a part of personal hygiene and was to be performed for the dependent residents. She confirmed the care plan for personal hygiene for nail care was developed but not implemented. Record review of admission Record revealed the facility admitted Resident #66 on 12/15/2020 with a diagnosis of Metabolic Encephalopathy. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/6/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment. Resident #89 Record review of Resident #89's Care Plan Report revealed Resident #89 has a functional abilities (Self-care and mobility) deficit related to impaired balance and musculoskeletal impairment. Under (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions.Personal Hygiene: She is dependent on 2 assistant to maintain personal hygiene. On 1/20/2026 at 2:55 PM, an observation and interview revealed Resident #89's fingernails were approximately one (1) inch long and jagged with a brown substance under them. Resident #89 revealed that she would like her fingernails to be trimmed and cleaned. On 1/21/2026 at 1:20 PM, an observation of Resident #89's fingernails remain long and jagged with a brown substance underneath them. During an interview and observation on 1/21/2026 at 3:50 PM, Certified Nurse Aide (CNA) #1 revealed we are responsible for cleaning the resident's fingernails when we clean them up each morning. She revealed the wound treatment nurse is responsible for cutting the nails if they are diabetic. CNA #1 confirmed that Resident #89's fingernails were long and jagged and stated, they are definitely dirty and need a good trimming. During an interview and observation on 1/21/2026 at 4:05 PM, the Director of Nurses (DON) revealed it is the responsibility of the CNA's to clean the residents' fingernails when they are providing daily care, and the nurses are responsible for ensuring the fingernails are adequately trimmed. The DON confirmed that Resident #89's fingernails were long and dirty, which could cause a skin tear and a possible infection. The DON confirmed that the resident's plan of care for her personal hygiene was not being followed and it should have been. Record review of the admission Record revealed that Resident #89 was admitted to the facility on [DATE] with diagnoses that included a displaced oblique fracture of the shaft of the right ulna and muscle weakness. Record review of the MDS Section C with an ARD of 1/15/2026 revealed a BIMS score of 8, which indicated Resident #89 has moderate cognitive impairment. Resident #61 Record review of Resident #61's Care Plans revealed under, Focus: (Proper name of Resident #61) has an ADL (activity of daily living) Self Care Performance Deficit r/t (related to) Stroke. Also revealed under, Intervention: She has contractures of bilateral hands, wash and dry bilateral hands, provide PROM (passive range of motion). Apply bilateral hand splints. Resident to wear bilateral hand splints for 8 hrs (hours) daily. During an observation of Resident #61 on 1/20/26 at 10:40 AM, she was lying in bed without hand splints. A hand/wrist splint was lying on the bedside dresser. An interview with a family member revealed staff did not apply them. On 1/21/26 at 9:48 AM, an observation of Resident #61 revealed there were no hand splints in place. On 1/22/26 at 8:36 AM, an observation revealed Resident #61 without hand splints. On 1/22/26 at 8:43 AM, an interview with Licensed Practical Nurse (LPN) #2 (Restorative Nurse) confirmed Resident #61's hand splints were not being applied as ordered. An interview with the Minimum Data Set (MDS) Nurse on 1/22/26 at 9:57 AM revealed the purpose of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan was to notify the staff of what care to provide for the residents. She confirmed Resident #61's care plan was not followed for the splints and stated there was a break in communication. Record review of the admission Record revealed the facility admitted Resident #61 on 2/26/24 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Middle Cerebral Artery and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed under section C, Resident #61's cognitive skills for daily decision making were severely impaired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide personal hygiene for two (2) of the twenty-one sampled residents. Resident #66 and Resident #89. Findings include: A review of the facility policy titled, Resident Hygiene Care of Fingernails/Toenails with a revision date of 6/2022, revealed The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. Nail care includes cleaning and trimming as needed. Proper nail care can aid in the prevention of skin problems around the nail bed. Resident #89 On 1/20/2026 at 2:55 PM, an observation and interview revealed Resident #89's fingernails were approximately one (1) inch long and jagged with a brown substance under them. Resident #89 revealed that she would like her fingernails to be trimmed and cleaned. On 1/21/2026 at 1:20 PM, an observation of Resident #89's fingernails remain long and jagged with a brown substance underneath them. During an interview and observation on 1/21/2026 at 3:50 PM, Certified Nurse Aide (CNA) #1 revealed we are responsible for cleaning the resident's fingernails when we clean them up each morning. She revealed the wound treatment nurse is responsible for cutting the nails if they are diabetic. CNA #1 confirmed that Resident #89's fingernails were long and jagged and stated, They are definitely dirty and need a good trimming. During an interview and observation on 1/21/2026 at 4:05 PM, the Director of Nurses (DON) revealed it is the responsibility of the CNA's to clean the residents' fingernails when they are providing daily care, and the nurses are responsible for ensuring the fingernails are adequately trimmed. The DON confirmed that Resident #89's fingernails were long and dirty, which could cause a skin tear and a possible infection. Record review of the admission Record revealed that Resident #89 was admitted to the facility on [DATE] with diagnoses that included a displaced oblique fracture of the shaft of the right ulna and muscle weakness. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 1/15/2026 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #89 has moderate cognitive impairment. Resident #66 During an interview and observation on 1/20/26 at 12:40 PM, Resident #66 revealed he liked his nails kept short and smooth and would like for them to be trimmed. Nails were observed to be approximately 1/4 inch from nail bed with a brown substance under several nails noted. Nails were jagged and rough in multiple areas. On 1/21/26 at 3:50 PM, during an interview and observation, the Director of Nursing revealed her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation was for each dependent resident to receive personal hygiene which included nail care. She acknowledged that Resident #66's nails were long, dirty, and jagged with sharp areas that could cause an injury to the skin. She confirmed the facility failed to maintain a resident's nails at an appropriate and safe length and in clean condition. Record review of admission Record revealed the facility admitted Resident #66 on 12/15/2020 with diagnosis of Metabolic Encephalopathy. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/6/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, family and staff interview, record review, and facility policy review, the facility failed to ensure prescribed splinting devices were applied as ordered for one (1) of (35) residents reviewed for range of motion impairments. Resident #61Findings Include:Record review of the facility policy titled Restorative Nursing Standard with a revision date of 3/19 revealed under, 4. Splints . Its purpose is to prevent deformities when an increase of tone is noted in hand and occasionally with a flaccid hand .On 1/20/26 at 10:40 AM, an observation of Resident #61 revealed she was lying in bed, nonverbal, with her eyes open. A hand/wrist splint was lying on the bedside dresser. She had contractures to both hands, with the left worse than the right. A soft hand roll was inside the left hand. An interview with a family member during this time revealed therapy previously applied hand splints to both hands; however, she no longer received therapy, and staff did not apply them. The family member stated he applies the right-hand splint for about an hour a day but does not apply the left-hand splint, confirming the resident still had both splints in the dresser drawer.An observation of Resident #61 on 1/21/26 at 9:48 AM, revealed there were no hand splints in place. Her left hand held a soft hand roll.Record review of Resident #61's Progress Notes dated 3/14/24 revealed a Restorative Care Referral was made to apply bilateral hand splints for 8 hours daily.Record review of Resident #61's Kardex revealed under, Restorative: .She has contractures of bilateral hands, wash and dry bilateral hands, provide PROM. (passive range of motion). Apply bilateral hands splints. Resident to wear bilateral hand splints for 8 (eight) hrs. (hours) daily.An interview with Certified Nurse Aide #2 on 1/22/26 at 8:34 AM, revealed she did not apply hand splints for Resident #61 and stated restorative was responsible.An observation on 1/22/26 at 8:36 AM, revealed Resident #61 without hand splints, with her left hand holding a soft hand roll.An interview with Licensed Practical Nurse (LPN) #2 (Restorative Nurse) on 1/22/26 at 8:43 AM, revealed the facility did not have a restorative program but was working to obtain staff to restart the program. She confirmed she did not apply Resident #61's splints and was not aware the resident was supposed to wear them. She stated she knew family was applying a splint at one time and confirmed if splints were not being applied as ordered, the contractures could worsen.An interview with the Rehabilitation Director on 1/22/26 at 9:10 AM, revealed the last time Resident #61 received occupational therapy for contractures and splinting was in February 2024. She revealed the resident was referred to restorative for splinting shortly thereafter and was screened quarterly with no changes in function identified. She confirmed if staff were not applying Resident #61's hand splints, her contractures could worsen.Record review of the admission Record revealed the facility admitted Resident #61 on 2/26/24 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Middle Cerebral Artery and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed under section C, Resident #61's cognitive skills for daily decision making were severely impaired.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. During observation, staff interviews, and facility policy/document review, the facility failed to ensure medications were secured properly to prevent unauthorized access for one (1) of three (3) days of survey.Findings include:Review of a Med Pass check off list with no date, revealed, .Medications locked within the cart when cart is out of direct line of vision. There was signature line for both the learner and observers' signature on the document.An observation on 1/20/2026 at 8:14 AM revealed an unlocked and unattended medication cart on the 200 unit with residents wandering in the immediate area. The medication cart contained various respiratory treatment medications used by the Respiratory Therapist. During an interview on 1/20/2026 at 8:15 AM, the Respiratory Therapist (RT) confirmed the medication cart was left unlocked and unattended. He further confirmed residents were wandering on the unit while the cart remained unlocked and unattended. He stated the importance of ensuring medications are stored in a locked cart or locked medication room and identified residents could be at risk if they accessed the unlocked cart. During an interview on 1/20/2026 at 10:30 AM, the Administrator confirmed all medication carts should be locked at all times unless in active use, particularly when left unattended. She further confirmed there was a risk if a resident accessed an unlocked medication cart.

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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. Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to ensure medications were accurately labeled and corresponded with the physician's order for two (2) of three (3) residents observed during medication pass. (Resident #5 and #20).Findings Include: Review of the pharmacy's policy titled Long Term Care Facilities/Pharmacy Operations/Medication Packaging: Strip Packaging with review date 04/2023, revealed: Strip packaging is provided for efficient and accurate medication administration and accountability of routine oral solid medications .Remember to always check your MAR prior to administering medications.Resident #5An observation during medication pass on 1/20/2026 at 9:44 AM revealed Licensed Practical Nurse (LPN) #5 retrieved a pharmacy-prepared multi-dose pouch labeled Omeprazole Oral Tablet Delayed Release 40 milligrams (mg) from the medication cart, opened the pouch and retrieved one (1) tablet, and administered it by mouth to Resident #5 along with other morning medications. During this observation, the January 2026 Medication Administration Record (MAR) did not match the Omeprazole Oral Tablet Delayed Release 40 mg tablets on hand in the multi-dose pouch, revealing a discrepancy between the physician's order and the labeled medication for Resident #5.Record review of Resident #5's January 2026 MAR revealed an order dated 8/22/2023 for Omeprazole Oral Tablet Delayed Release 20 mg, Give (2) tablets by mouth one time a day for Gastroesophageal Reflux Disease (GERD).Review of Resident #5's pharmacy-prepared multi-dose pouch dated for 1/20/2026 morning medication administration revealed, Omeprazole Oral Tablet Delayed Release 40 mg Give (1) tablet by mouth one time a day for GERD.During an interview on 1/20/26 at 9:45 AM, LPN #5 confirmed Resident #5's physician order and medication label did not match. She stated the discrepancy had been present for some time and stated, I've never thought to get it changed. During an interview on 1/20/26 at 2:30 PM, the Director of Nursing (DON) acknowledged the labeling inaccuracy created the possibility a nurse could administer an incorrect dose. She stated she was unaware of the discrepancy and that nursing staff should have reported so it could have been corrected.Record review of Resident #5's Face Sheet revealed the facility admitted the resident on 8/21/2023 with diagnoses including Metabolic Encephalopathy and Gastro-Esophageal Reflux Disease without Esophagitis. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/25 under section C revealed a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated Resident #5 was cognitively intact.Resident #20An observation during medication pass on 1/20/26 at 8:22 AM revealed LPN #4 retrieved a pharmacy-prepared multi-dose pouch labeled Desmopressin Acetate Tablet 0.2 mg from the medication cart, opened the pouch and retrieved (1) tablet, and administered it via Percutaneous Endoscopic Gastronomy (PEG) tube to Resident #20 along with other morning medications. During this observation, the MAR did not match the Desmopressin Acetate Tablet 0.2 mg tablets on hand in the multi-dose packet, revealing a discrepancy between the physician order and the labeled medication for Resident #20.Record review of Resident #20's January 2026 MAR revealed an order dated 5/6/2020, Desmopressin Acetate Tablet 0.1 mg. Give (2) tablets via PEG-Tube three times a day for diabetes insipidus.Review of Resident #20's pharmacy-prepared multi-dose pouch dated for 1/20/2026 AM medication administration revealed, Desmopressin Acetate Tablet 0.2 mg Give one (1) tablet via PEG-Tube three times a day and Baclofen Tablet 10 mg Give 0.5 tablet via PEG-Tube two times a day for seizures. An interview with LPN #4 on 1/20/26 at 8:22 AM, confirmed Resident #20's physician order and medication label did not match. She stated this discrepancy could easily cause a nurse to administer the wrong amount. She further stated that the facility changed pharmacy providers a few months ago and she had noticed the variations but had not notified anyone to have the issue corrected.An interview with the DO) on 1/20/26 at 2:30 PM, acknowledged that the labeling inaccuracy created the possibility that a nurse could administer an incorrect dose. She stated she was unaware of the discrepancy, and the nurse (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have reported so it could have been corrected.Record review of Resident #20's Face Sheet revealed the facility admitted the resident on 8/30/2019 with diagnoses including Unspecified Intracranial Injury with loss of consciousness of unspecified duration, subsequent encounter and Persistent Vegetative State.A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/25 revealed under section C that the BIMS was conducted by staff assessment for daily decision making and were coded as (3) indicating severely impaired-never/rarely made decisions.