STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255219	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Walk Healthcare Center	570 North Solomon Street Greenville, MS 38703

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff and resident interviews, record review, and facility policy review, the facility failed to ensure each resident's right to remain free from sexual abuse for one (1) of three (3) residents reviewed for abuse. Resident #1. Based on the implementation of corrective actions on 1/5/26, the State Agency (SA) determined the deficiency to be Past Non-Compliance and the facility was in compliance as of 1/6/26, prior to the SA entrance on 1/12/26. Findings Included: Record review of the facility policy titled, Abuse Prohibition revealed Policy Statement, To assure the prohibition of abuse, neglect, mistreatment, and the misappropriation of property of all residents . Record review of the facility investigation revealed that on 12/31/25 at 3:00 PM, the Administrator (ADM) received an allegation of sexual abuse that occurred on the afternoon of 12/27/25, when Certified Nursing Assistant (CNA) #1 observed Resident #2 in the room of Resident #1 with his hand in her brief and his mouth on her breast. Further review of the investigation revealed Resident #2 was placed on every fifteen (15) minute visual monitoring and kept separate from Resident #1. An interview with Resident #1 on 1/12/26 at 2:30 PM, revealed she stated that on 12/27/25, Resident #2 was in the room visiting Resident #3. She stated he rubbed her leg on the outside area of her thigh and the side of her breast. She stated she told him to stop, and he did stop and left the room. She denied any skin-to-skin contact. An interview with Resident #3 on 1/12/26 at 3:00 PM, revealed she stated she witnessed Resident #2 rubbing Resident #1 and pointed to her groin area. In an interview with Resident #2 on 1/12/26 at 3:30 PM, he stated that on the afternoon of 12/27/25, he was in Resident #1's room visiting with Resident #3. He stated he rubbed Resident #1 across the thigh and her belly. Interview with the Administrator on 1/12/26 at 5:00 PM, revealed she verified she received the allegation on 12/31/25 at approximately 3:00 PM, separated the residents, and had Resident #1 assessed for injuries. Resident #2 was placed on visual monitoring and was transferred to the hospital for evaluation from 1/1/26 through 1/7/26. Upon return, he was moved to a room at the opposite end of the facility, visual monitoring was resumed, and he no longer visits Resident #3 in her room. She verified interviewable residents were interviewed regarding allegations of abuse with no other concerns identified, and the non-interviewable residents were assessed for signs of abuse with none were identified. CNA #1 was suspended pending investigation and subsequently terminated for not reporting immediately. Staff were in-serviced on abuse and resident rights. She began conducting staff interviews three (3) days per week regarding potential abuse allegations and will continue for four (4) weeks. She confirmed the incident and investigation results were presented to the Quality Assurance (QA) committee during the committee meeting on 1/2/26, during which the facility policy was reviewed with no revisions made. She verified Resident #2 will remain on every fifteen (15) minute monitoring while he is a resident in the facility.Record review of the admission Record revealed that the facility admitted Resident #1 on 8/27/21 with diagnosis of Schizophrenia.Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/28/25, revealed Resident #1 had a (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brief Interview for Mental Status (BIMS) score of four (4) which indicated severely impaired cognition. Record review of the admission Record revealed that the facility admitted Resident #2 on 10/29/21 with a diagnosis of Heart Failure.Record review of the MDS, with an ARD of 11/22/25, revealed Resident #2 had a BIMS score of 15 which indicated no cognitive deficits. Record review of the admission Record revealed that the facility admitted Resident #3 on 5/16/22 with a diagnosis of Cerebral Infarction.Record review of the MDS, with an ARD of 10/13/25, revealed Resident #3 had a BIMS score of 4 indicating severe cognitive impairment. Based on the implementation of the facility's corrective actions on 1/5/26, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 1/6/26, prior to the State Agency entrance on 01/12/26. The SA validated on 1/12/26, through interview and record review, that all corrective actions had been implemented as of 1/5/26, and the facility was in compliance as of 1/6/26, prior to the SA's entrance on 1/12/26.