STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health & Rehab LLC	230 River Oaks Drive Canton, MS 39046

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on dialysis staff and facility staff interview, record review, and facility policy review, the facility failed to promptly notify the physician of a resident change in both nutrition and hydration status for one (1) of four (4) residents reviewed for nutrition. Resident #12 Cross Reference F692 Findings Include: Review of the facility policy titled Change in a Resident's Condition or Status with a revision date of May 2017, revealed, Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . Record review of Resident #12's MAR revealed an order dated 1/09/25, Dialysis Fluid Restriction 1,500cc (cubic centimeters). Record review of the Registered Dietician Note dated 2/18/25 for Resident #12 revealed, RD (Registered Dietician) spoke with RD from dialysis regarding resident having issues with fluid overload. RD suggests changing TF (tube feeding) to Nutren 2.0 in order to meet needs for weight gain/wound healing without having excess fluids to prevent overload. Dialysis RD agrees and will monitor dialysis labs for elevated phosphorous. Dialysis RD states that fluid restriction for resident is 1000 ml (milliliters) H20 (water), however online orders (facility physician orders) show 1500 ml (milliliters) H20 (water). Additionally revealed under, Interventions: 1. Consult MD (physician) for fluid restriction clarification. 2. Change TF (tube feeding) to Nutren 2.0 (1) can five (5) times per day. Flush with 50 ml (milliliters) H20 (water) after each feeding. TF (tube feeding) will provide 2500 calories, 100 grams protein, 1125 milliliters free H20 (water) 1500 milliliters total H20 (water). 3. Change med flushes to 15 ml (milliliters) H20 (water) before and after meds. Med flushes will provide 60-90 milliliters H20 (water). Goal: WG (weight gain) to IBW (ideal body weight), TF (tube feeding) to meet needs for dialysis and desired WG (weight gain). Record review of Resident #12's Medication Administration Record (MAR) revealed the RD recommendations dated 2/18/25 were not implemented. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's MAR revealed an order dated 2/12/25, Enteral Feed Order . Nepro 1 can six (6) times per day via bolus. Flush with 30 ml (milliliters) H20 (water) after each feeding. Tube feeding will provide: 2560 calories, 115 grams protein, 1394 cc (cubic centimeter) free H20 (water), 1782 cc (cubic centimeter) total H20 (water). Also revealed an order dated 3/7/25, Enteral Feed Order every shift: Flush peg tube (Percutaneous Endoscopic Gastrostomy) with 15cc (cubic centimeters) of water before and after administration of medication and 5cc (cubic centimeters) in between each medication. A telephone interview with the facility RD on 3/12/25 at 10:40 AM revealed she last saw Resident #12 in the facility on 2/18/25. She revealed she called and spoke with the dialysis RD. The RD revealed that after speaking with the Dialysis RD, she was made aware that the resident should be on a 1200 ml fluid restriction. The RD explained that she made recommendations that day to change the enteral feedings to Nutren 1 can bolus 5 times daily and to change up the flushes. She revealed she also recommended contacting the MD for a clarification on the fluid restriction. She revealed she gave the recommendation to the Director of Nursing or the Assistant Director of Nursing while she was at the facility. An interview with the Director of Nursing (DON) on 3/12/25 at 10:53 AM confirmed the RD recommendations should have been put into place for Resident #12. She explained that she remembered talking to the RD and then going back and forth about his changes. The DON revealed the RD recommendation must have been misplaced because she was unable to locate it. She revealed once the RD makes a recommendation, it was given to her, and she placed it in the physician's folder for him or the nurse practitioner to review. A telephone interview with Proper Name of Dialysis Company RD on 3/12/25 at 1:18 PM revealed the facility had the resident on a 1500 ml (milliliter) fluid restriction, which was not what the dialysis physician had ordered. The RD revealed that she faxed a 1200 ml (milliliter) fluid restriction physician order to the facility on [DATE]. A follow up interview with the DON on 3/12/25 at 2:48 PM confirmed that the physician was not made aware of Resident #12's new RD recommendations via telephone because she thought the nurse practitioner intended to come to the facility a couple of days later and could have reviewed it then. She acknowledged the physician should have been made aware as the resident had had a delay getting the care. Record review of the Dialysis Orders Log for Resident #12 revealed an order dated 2/20/25, Patient to follow a fluid restricted diet, limiting fluid intake to 1200 ml (milliliters) per day. Monitor fluid closely and report any concerns to dialysis unit. Record review of the Admission Record revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, staff and resident interviews, record review, and facility policy, the facility failed to ensure a resident's right to be free from physical restraints when a bed alarm pad and a wheelchair alarm pad were used that restricted the resident's movements. The alarms caused the resident to stop moving to avoid triggering the alarm sounds, demonstrating a restrictive effect for one (1) of two (2) residents reviewed for restraints. (Resident #67) Findings include: Review of the facility policy titled Use of Restraints, revised April 2017, revealed Policy Interpretation and Implementation: 'Physical Restraints' are defined as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . An observation and interview with Resident #67 on 3/11/25 at 10:15 AM revealed a bed alarm pad attached to the resident's bed. During the interview, Resident #67 stated that the bed alarm went off frequently and voiced, I hate it. He reported that when the alarm sounds, he stops moving so it will stop alarming. During an interview with Certified Nurse Assistant (CNA) #6 on 3/13/25 at 8:16 AM, she confirmed that Resident #67 had a bed alarm pad in place due to a history of frequent falls. When asked if the resident had ever complained about the alarm pad, CNA #6 stated that she had observed the resident stop moving or attempting to get up when the alarm sounded, as he did not want it to continue. When asked if she reported this behavior, she stated that she believed she did. A record review of the Order Summary report for Resident #67 revealed no physician order for a bed alarm pad. Further review revealed an order dated 10/15/24 for a wheelchair/chair alarm pad to alert staff of attempts to get up unassisted. An interview with the Medicare Nurse on 3/12/25 at 8:35 AM confirmed that if Resident #67 stated he stops moving to make the alarm stop and staff reported observing the resident stopping movement in response to the alarm, the alarms would be considered a restraint. She confirmed that no restraint assessments had been completed for either alarm devices because she was unaware that the alarm was restricting the resident's movement. She also revealed the resident only had an alarm pad ordered for the wheelchair and was not aware that he had an alarm pad to the bed. During an interview with the Director of Nursing (DON) on 3/13/25 at 8:50 AM revealed that she was unaware that Resident #67 had voiced his dislike for the alarm or that it caused him to stop moving. She confirmed that while the resident had an order for an alarm pad on the wheelchair, there was no order for an alarm pad on the bed. The DON stated she did not know when or by whom the bed alarm pad was placed. She confirmed that if the resident expressed distress about the alarm and staff verified his behavior of stopping movement to silence it, both alarm devices would be considered restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 3/13/25 at 3:34 PM revealed concerns about the use of restraints, stating that they could lead to anxiety or depression and hinder residents from performing daily activities independently. Record review of the Admission Record revealed Resident #67 was admitted on [DATE], with a diagnoses which included Repeated Falls. A record review of Resident #67's Minimum Data Set (MDS), Section C with an Assessment Reference Date (ARD) of 2/12/2025, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was severely cognitively impaired.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 47874 Based on staff interview, record review, and facility policy review, the facility failed to accurately complete section N of the Minimum Data Set (MDS) for a resident taking an antiplatelet medication for one (1) of 23 MDS assessments reviewed. Resident #42 Findings Include: Review of the facility policy titled Resident Assessment Instrument with a revision date of September 2010 revealed under, Policy Statement: A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. Additionally revealed, 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practical level of functioning. Record review of the Annual MDS with an Assessment Reference Date (ARD) of 12/3/24 revealed, under Section N, Resident #42 was coded as receiving an anticoagulant (blood thinner) medication during the 7-day look back period. Record review of the Medication Administration Record (MAR) for November and December 2024 revealed Resident #42 did not receive an anticoagulant (blood thinner) medication. Additionally, the resident did receive the antiplatelet medication Plavix. An interview with the Medicare Nurse on 3/12/25 at 9:40 AM confirmed Resident #42 did not receive an anticoagulant medication and revealed that Section N was coded wrong. She explained that the antiplatelet box should have been marked. The Medicare Nurse revealed they follow the Resident Assessment Instrument (RAI) manual for guidance in completing the assessments, and acknowledged Resident #42's MDS should be accurate to reflect the resident's status. Record review of the Admission Record revealed the facility admitted Resident #42 on 1/04/23 with a medical diagnosis that included Alzheimer's Disease.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46013 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to develop and/or implement care plans related to Activities of Daily Living (ADL) care for Residents #1, #34, #61 and #67, failed to develop a care plan related to Post-Traumatic Stress Disorder (PTSD) for Resident #41, and failed to develop a care plan related to activities for Resident #68. Additionally, the facility failed to implement a care plan intervention for a contracture device for Resident #12 for seven (7) of 23 resident care plans reviewed. The scope/severity of this deficiency was increased to E Pattern due to prior citation on the last Annual Recertification Survey. Findings include: Record review of the policy titled, Care Plans, Comprehensive Person-Centered, revised December 2016, revealed its Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident # 1 Record review of Resident #1's ADL care plan revealed, Focus: Resident requires supervision-total assistance with ADL's r/t (related to) impaired mobility urostomy and colostomy status right aka above knee amputation) left bka (below knee amputation), DM . Interventions .Shave resident prn (as needed) .Shower three (3) times a week sponge bath on other days. On 3/11/25 at 9:34 AM, an observation and interview revealed Resident #1's facial hair was approximately 3/4 inch long on his chin, sides of his face, and neck area. His hair was unkempt and thick. Resident #1 revealed the barber hadn't been here in quite some time; and stated I would like to have a haircut and be shaved. He revealed no one had asked him if he wanted to be shaved or have a haircut, and it's been a very long time. On 3/12/25 at 9:35 AM, during an observation and interview the Director of Nurses (DON) confirmed that Resident #1 needed to be shaven, and his hair needed to be cut. The DON confirmed that Resident #1 had a care plan to shave the resident prn, and his plan of care was not being followed. A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with Hypoglycemia without Coma, and Functional Quadriplegia. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/25 revealed, in Section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Resident #61 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #61's ADL care plan revealed, Focus: Resident requires assistance with ADLs 's d/t (due to) decreased mobility, colostomy status, incontinence of bladder, schizophrenia and depression . Interventions. Shower 3 times a week sponge bath on other days. On 3/11/25 at 9:55 AM, an observation and interview revealed Resident #61 had facial hair approximately one and a half inches long to his cheeks, chin, and neck and hair that was unkempt, long, and greasy. Resident #61 stated it's been a long time since he had been shaved and had a haircut. During an interview on 3/12/25 at 3:05 PM, the DON confirmed that the staff is responsible for addressing the residents' grooming needs daily and ensuring they are adequately groomed, which includes shaving and hair care. During an interview on 3/12/25 at 1:30 PM, the Medicare Nurse revealed she and the MDS nurse are responsible for developing the residents' nursing care plans. She revealed that the purpose of the care plan is to paint a thorough picture of the resident's individualized needs, and anyone can look at their care plan and know exactly their needs. She confirmed that the care plan for Resident #61 was not developed to reflect his shaving and that it should have been. After reviewing the care plans for Resident #1 and Resident #61, she revealed they were very vague about the interventions needed for their hygiene and grooming needs. A record review of Resident #61's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Paranoid Schizophrenia and Depression. A record review of the MDS with an ARD of 01/06/25 revealed, in Section C, a BIMS score of 15, which indicated Resident #61 was cognitively intact. Resident #41 Record review of Resident #41's Admission Record revealed the resident was readmitted to the facility on [DATE] with medical diagnoses that included Post Traumatic Stress Disorder (PTSD), and Bipolar Disorder. Record review of Resident #41's Care Plan Detail revealed under, Focus: Resident has a dx (diagnosis) of PTSD related to killing other humans with a machine gun in combat. Resident has experienced other trauma such as death of close family, being assaulted in lifetime. Under, Interventions/Tasks, the care plan was not developed for triggers or trigger-specific interventions. On 3/12/25 at 8:35 AM, during an interview, Resident #41 confirmed that he does have PTSD that stems from when he came home from Vietnam and the treatment that he received during the war. In an interview on 3/12/25 at 8:50 AM, CNA #5 revealed Resident #41 doesn't have behaviors now, but he use to have a lot of behaviors. She stated that she wasn't sure if the resident had PTSD or not. On 3/12/25 at 9:40 AM, in an interview the Social Worker (SW) stated that she didn't know what Resident #41's triggers were. She revealed she had never discussed his PTSD or triggers with the him and confirmed he did not have a PTSD care plan that addressed any triggers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 10:00 AM, during an interview the DON confirmed that Resident #41 has PTSD. She revealed his trigger were being awakened in the middle of the night by staff knocking on the door and entering the room. She confirmed that the resident did not have a PTSD care plan that addressed trigger-specific interventions, so therefore the staff were not made aware so that they could try and prevent re-traumatization. Record review of Resident #41's MDS with an ARD of 1/15/2025 revealed in Section C, a BIMS score of 15, which indicated the resident is cognitively intact. 47874 Resident #12 Review of Resident #12's Care Plan revealed, The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) decreased mobility and function, incontinent of bowel and bladder, HTN (hypertension), PVD (peripheral vascular disease), GERD (gastroesophageal reflux disease), Pain, ESRD (end stage renal disease), multi contractures, Hx (history) dysphagia. Additionally revealed under, Interventions/task: Resident will wear resting hand splint on LUE (left upper extremity) x (times) 4-6 hours daily, report to OT (occupational therapy) any complications. On 3/11/25 at 9:37 AM, an observation of Resident #12 revealed he was lying in bed with a left upper extremity contracture without a device in place. On 3/12/25 at 8:08 AM and again at 9:30 AM, an observation of Resident #12 revealed he was lying in bed without a contracture device in place on the left extremity. On 3/12/25 at 9:45 AM, an observation and interview with the Assistant Director of Nursing (ADON) confirmed Resident #12 was not wearing the ordered splint. An interview with the Medicare Nurse on 3/13/25 at 8:02 AM confirmed the staff did not follow the care plan for Resident #12's splinting device. Record review of the Admission Record revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 5 Chronic Kidney Disease and End Stage Renal Disease. Resident #68 Record review of Resident #68's Care Plans revealed a care plan was not developed for activities. An interview with the Medicare Nurse on 3/13/25 at 8:05 AM confirmed an activity care plan was not developed for Resident #68 and should have been. She revealed the Activity Director is responsible for developing the activity care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Activity Director (AD) on 3/13/25 at 8:20 AM revealed she had been working at the facility for one year. She revealed Resident #68 did participate in activities but was more of a sit and watch person due to her poor attention span even though she did like to talk. The AD admitted that when the facility changed charting systems in August 2024 she did not develop an activity care plan for the resident and confirmed that it should have been done to determine the resident's functional abilities and preferences. Record review revealed the facility admitted Resident #68 on 3/07/23 with a medical diagnosis that included Dementia. 48845 Resident #34 Record review of Resident #34's care plan related to ADLs, last revised on 10/11/2024, revealed the focus area indicated that he required extensive assistance with personal hygiene related to muscle weakness, decreased mobility, pain, and history of falls. Interventions/tasks revealed resident requires extensive assistance with personal hygiene. On 3/11/25 at 10:30 AM, an observation and interview revealed Resident #34 to be unshaven and his hair appeared oily with visible white flakes around the scalp edges. He expressed a desire to be shaved and have his hair washed but was unable to recall the last time he received such care. Record review of Resident #34's MDS Kardex Report also noted that he required extensive assistance with personal hygiene. An interview on 3/12/25 at 8:31 AM, with the Medicare Nurse confirmed, after reviewing the ADL care plan for Resident #34, that staff had not implemented the required personal hygiene interventions outlined in the ADL care plan. Record review of Resident #34's Admission Record revealed he was admitted to the facility on [DATE], with diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 1 through Stage 4 Chronic Kidney Disease, and Malignant Neoplasm of Bladder. Record review of Resident #34's MDS Section C, with an ARD of 12/16/2024, revealed a BIMS score of 14, indicating the resident was cognitively intact .Section GG 0130 Self Care was coded dependent. 47157 Resident #67 A review of Resident #67's Care Plan titled, Resident requires assistance with ADLs r/t incontinence, dementia, and muscle weakness, last revised on 2/16/25, revealed no interventions related to personal hygiene assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 10:00 AM, during an observation and interview with Resident #67 the resident was noted to be unshaven with unkempt facial hair and his face and hair appeared oily. When asked about his personal care routine, the resident stated he had not been shaved in a while and could not recall when his hair was last washed. An interview with the Medicare Nurse on 3/13/25 at 8:35 AM confirmed that after reviewing Resident #67's ADL care plan, it was not developed to include personal hygiene interventions. She stated that comprehensive care plans should accurately reflect a resident's needs and guide staff in providing necessary care. An interview with the DON on 3/13/25 at 8:50 AM acknowledged that if care plans related to ADL's do not include personal hygiene interventions, staff may not provide essential hygiene assistance, leading to unmet care needs. A review of Resident #67's Admission Record revealed that he was admitted on [DATE], with a diagnosis of Infrarenal Abdominal Aortic Aneurysm. A review of the MDS Section C with an ARD of 2/12/25, revealed a BIMS score of 7, indicating severe cognitive impairment. Section GG ADL was coded as Item 01301 Personal Hygiene dependent.

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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 for residents that require assistance for four (4) of seventy-nine (79) residents observed during the initial tour. Resident's #1, #34, #61 and #67 The scope/severity of this deficiency was increased to E - Pattern due to prior citation on the last Annual Recertification Survey. Findings include: Review of the facility policy titled, Quality of Life, revised August 2009, revealed Policy Interpretation and Statement: 3.) Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc. (et cetera). Resident #1 An observation and interview on 3/11/25 at 9:34 AM revealed Resident #1's facial hair was approximately 3/4 inch long on his chin, sides of his face, and neck area. His hair was unkempt and thick. Resident #1 stated, The barber has not been here in quite some time. I would like to have a haircut and be shaved. He admitted that no one had asked him if he wanted to be shaved or have a haircut, and it's been a very long time. An observation on 3/12/25 at 8:20 AM revealed Resident #1 with no change in appearance from the previous day. During an interview and observation on 03/12/25 at 9:25 AM, Certified Nurse Aide (CNA) #1 revealed she was assigned to Resident #1 and confirmed he had long facial hair and needed a haircut. She admitted she was not sure if the resident wanted to be shaved because she had not asked and confirmed that she should have put him down on the barber list for a haircut. During an observation and interview on 3/12/25 at 9:35 AM, the Director of Nurses (DON) confirmed that Resident #1 needed to be shaven, and his hair needed to be cut. She stated, He's able to tell the staff when he wants it to be done. Resident #1 replied, But I don't know when the man comes to cut our hair. He stated to the DON that he had his haircut last year, and the barber also shaved him at that time, but that was the last time he was shaven. Resident #1 then confirmed that he would like to be shaved and have his hair cut. A record review of the Daily Barber Shop Charges revealed Resident #1's last haircut was on 10/8/24. A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with Hypoglycemia without Coma, Tachycardia, and Functional Quadriplegia. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health & Rehab LLC	230 River Oaks Drive Canton, MS 39046

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed, in Section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Resident #61 An observation and interview on 3/11/25 at 9:55 AM revealed Resident #61 had facial hair approximately 1.5 (one and one-half) inches long to his cheeks, chin, and neck and his hair was long, and greasy. Resident #61 admitted that it had been a long time since he had been shaved and had a haircut, and he wanted to have those things taken care of. An observation on 3/12/25 at 8:20 AM revealed Resident #61 with no change in appearance from the previous day. In an interview and observation on 3/12/25 at 8:55 AM, CNA #5 confirmed that Resident #61 needed to be shaved and have his hair washed and cut. She revealed that she was assigned to Resident #61 today and stated that he was looking rough. She then stated that she wasn't sure how long it had been since the resident had a haircut or had been shaved. A record review of Resident #61's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Hypokalemia and Depression. A record review of the MDS with an ARD of 1/6/25 revealed, in Section C, a BIMS score of 15, which indicated Resident #61 was cognitively intact. 48845 Resident #34 An observation and interview on 3/11/25 at 10:30 AM, revealed Resident #34's hair was greasy with white flakes around the scalp edges and his face had visible facial hair. He stated he could not remember the last time his hair was washed, or he was shaved but he wanted it done. An observation on 3/12/25 at 8:25 AM, with CNA #4, confirmed that Resident #34 appeared to have gone without a shower or hair wash for an extended period. An observation on 3/12/2025 at 8:27 AM, with Registered Nurse (RN) #3, she confirmed Resident # 34 looked scruffy and unkempt. Record review of Resident #34's Admission Record revealed he was admitted to the facility on [DATE], with diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 1 through Stage 4 Chronic Kidney Disease, and Malignant Neoplasm of Bladder. Record review of Resident #34's MDS Section C, with an ARD of 12/16/2024, revealed a BIMS score of 14, indicating the resident was cognitively intact. Section GG 0130 Self Care was coded dependent. 47157 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #67 During an observation and interview with Resident #67 on 3/11/25 at 10:00 AM, the resident's face and hair appeared oily with long unkempt facial hair. The resident stated he had not been shaved in a while and could not remember when his hair was last washed. An observation with CNA #6 on 3/12/25 at 8:16 AM confirmed that Resident #67's facial hair was unkempt, needed to be shaved, and his face and hair were oily and needed washing. During an interview with the DON on 3/13/25 at 8:50 AM, she confirmed that all residents should receive personal hygiene daily and as needed. She acknowledged that a lack of personal hygiene could lead to potential skin issues. Review of the ADL documentation for Resident #67 from 2/27/25-3/12/25 revealed only two days of documentation for personal hygiene. A review of Resident #67's Admission Record revealed that he was admitted on [DATE], with a diagnosis of Infrarenal Abdominal Aortic Aneurysm. A review of the MDS, Section C, dated 2/12/25, revealed a BIMS score of 7, indicating severe cognitive impairment. A review of the MDS-Nursing (7) Seven-Day Look Back Report dated 3/12/25 documented that Resident #67 was coded as dependent for Section GG: 01301 - Personal Hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a splint was applied for a resident with contractures for one (1) of 35 residents with limited range of motion (ROM) residing in the facility. Resident #12 The scope/severity of this deficiency was increased to E Pattern due to prior citation on the last Annual Recertification Survey. Findings Include: Review of the facility policy titled Resident Mobility and Range of Motion with a revision date of July 2017, revealed under, Policy Statement: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable . An observation of Resident #12 on 3/11/25 at 9:37 AM revealed he had a left upper extremity contracture with no contracture device in place. An observation of Resident #12 on 3/12/25 at 8:08 AM and again at 9:30 AM revealed the resident continued to have no device in place for the left extremity contracture. Record review of Resident #12's March 2025 Medication Administration Record (MAR) revealed an order dated 6/11/24, Resident to wear resting hand splint to LUE (left upper extremity) daily. Put on at 8:00 AM. Leave on resident 4-6 hours as resident will allow. One time a day to prevent declining contracture report to OT (Occupational Therapy) any complications. An observation and interview with the Assistant Director of Nursing (ADON) on 3/12/25 at 9:45 AM confirmed Resident #12 was not wearing the ordered splint. She revealed the aides were responsible for applying the device and the nurses were to ensure it was applied. The ADON revealed failing to apply the splint could cause worsening contractures. An interview with Licensed Practical Nurse (LPN) #3 on 3/12/25 at 9:51 AM confirmed she did not ensure Resident #12 had on his hand splint yesterday or today. She revealed she was unsure where the splint was but thought it could be in the laundry. She confirmed she signed off on the MAR as administered yesterday and admitted she did not go back to ensure it was applied. An interview with Certified Nurse Aide (CNA) #1 on 3/12/25 at 10:15 AM revealed she worked last night, and Resident #12 did not have his splint in his room. She stated, I guess someone took it to laundry because he didn't have it. She confirmed she did not look for it. (continued on next page)

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F 0688 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 (ARD) of 12/26/24 revealed under section GG, Resident #12 had upper extremity (shoulder, elbow, wrist, hand) functional limitation in Range of Motion (ROM) on both sides. Record review of the Admission Record revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on dialysis staff and facility staff interview, record review, and facility policy review, the facility failed to provide nutritional and hydration care and services to meet the needs of a resident receiving both enteral feedings and dialysis for one (1) of four (4) residents reviewed for nutrition. Resident #12 Cross reference F580 Findings Include: Review of the facility policy titled Enteral Nutrition with a revision date of January 2014, revealed under, Policy Statement: adequate nutritional support through enteral feeding will be provided to residents as ordered. Additionally revealed under, 8. The Dietician will monitor residents who are receiving enteral feedings and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings . Record review of the Registered Dietician Note dated 2/18/25 for Resident #12 revealed, RD (Registered Dietician) spoke with RD from dialysis regarding resident having issues with fluid overload. RD suggests changing TF (tube feeding) to Nutren 2.0 in order to meet needs for weight gain/wound healing without having excess fluids to prevent overload. Dialysis RD agrees and will monitor dialysis labs for elevated phosphorous. Dialysis RD states that fluid restriction for resident is 1000 ml (milliliters) H20 (water), however online orders (facility physician orders) show 1500 ml (milliliters) H20 (water). Additionally revealed under, Interventions: 1. Consult MD (physician) for fluid restriction clarification. 2. Change TF (tube feeding) to Nutren 2.0 (1) can 5 times per day. Flush with 50 ml (milliliters) H20 (water) after each feeding. TF (tube feeding) will provide 2500 calories, 100 grams protein, 1125 milliliters free H20 (water) 1500 milliliters total H20 (water). 3. Change med flushes to 15 ml (milliliters) H20 (water) before and after meds. Med flushes will provide 60-90 milliliters H20 (water). Goal: WG (weight gain) to IBW (ideal body weight), TF (tube feeding) to meet needs for dialysis and desired WG (weight gain). Record review of Resident #12's Medication Administration Record (MAR) revealed the RD recommendations dated 2/18/25 were not put in place. Record review of Resident #12's MAR revealed an order dated 2/12/25, Enteral Feed Order . Nepro 1 can 6 times per day via bolus. Flush with 30 ml (milliliters) H20 (water) after each feeding. Tube feeding will provide: 2560 calories, 115 grams protein, 1394 cc (cubic centimeter) free H20 (water), 1782 cc (cubic centimeter) total H20 (water). Also revealed an order dated 3/7/25, Enteral Feed Order every shift: Flush peg tube (Percutaneous Endoscopic Gastrostomy) with 15cc (cubic centimeters) of water before and after administration of medication and 5cc (cubic centimeters) in between each medication. Record review of Resident #12's MAR revealed an order dated 1/09/25, Dialysis Fluid Restriction 1,500cc (cubic centimeters). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:40 AM, a telephone interview with the facility RD revealed the last time she saw Resident #12 was on 2/18/25. She stated that she talked with the dialysis RD because the resident was having fluid overload during his dialysis treatments. She admitted they also discussed concerns about the resident's enteral feedings and not gaining weight. The RD revealed that after speaking with the dialysis RD, she was made aware that the resident should be on a 1200 ml fluid restriction. The RD explained that she made recommendations to the Director of Nurses (DON) or the Assistant Director of Nurses (ADON) that day to change the enteral feedings to Nutren 1 can bolus 5 times daily and to change up the flushes. She revealed she also recommended contacting the MD for a clarification on the fluid restriction. Furthermore, she confirmed failure to act promptly on these recommendations could place the resident at risk for continued fluid overload. On 3/12/25 at 10:53 AM, an interview with the DON confirmed that she remembered talking to the RD and then going back and forth about Resident #12's changes. She revealed that once the RD makes a recommendation, she usually places it in the physician's folder for him or the nurse practitioner to review. She admitted that those recommendations must have been misplaced because she was unable to locate it and confirmed that they should have been put into place. On 3/12/25 at 1:18 PM, a telephone interview with Proper Name of Dialysis Company RD confirmed she spoke with the Facility RD related to Resident #12 being NPO (nothing by mouth) and receiving Nepro enteral feedings and losing weight, plus concerns related to the resident's interdialytic (between dialysis sessions) weight gain. She stated that she had faxed a 1200 ml (milliliter) fluid restriction physician order to the facility on [DATE], but the facility continued to have the resident on a 1500 ml (milliliter) fluid restriction. She expressed that the resident was normally over his pre-dialysis target weight with excessive fluid. She confirmed that if the resident did not follow the recommended fluid restriction, and the RD recommended enteral feedings/flushes then that could result in elevated blood pressure. Record review of the (Proper Name Dialysis) Orders Log for Resident #12 confirmed an order dated 2/20/25, Patient to follow a fluid restricted diet, limiting fluid intake to 1200 ml (milliliters) per day. Monitor fluid closely and report any concerns to dialysis unit. On 3/12/25 at 1:26 PM, a telephone interview with Proper Name of Dialysis Company Registered Nurse (RN) Clinical Director revealed that Resident #12 was normally 3-4 kilo's (kilograms) (6.6 to 8.8 pounds) over on his pre-dialysis weight and the goal was not to be above 1 kilo (2.2) pounds or to exceed 2 kilos (4.4) pounds. She stated that the residents' last visit was on Monday 3/10/25, and he was 4 kilos (8.8) pounds over. An interview with the DON on 3/12/25 at 2:48 PM revealed the physician was not made aware of Resident #12's new Registered Dietician (RD) recommendations via telephone because the nurse practitioner intended to come to the facility a couple of days later and could review it then. She confirmed the resident's fluid volume status was of high importance and acknowledged the physician should have been made aware as the resident had had a delay getting the care. She revealed they (the facility) did not receive the faxed physician order from dialysis to reduce Resident #12's fluid restriction to 1200 milliliters. Record review of the Weights and Vitals Summary for Resident #12 revealed the following weights: 12/03/24 115.3 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/26/24 110.4 pounds 1/03/25 - 106.9 pounds 1/17/25 - 109.1 pounds 2/03/25 - 117.7 pounds 2/17/25 - 116.6 pounds 3/07/25 - 112.6 pounds Record review of the Admission Record revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff and resident interview, record review and facility policy review, the facility failed to ensure care was delivered to a resident with Post Traumatic Stress Disorder (PTSD) in a manner that would minimize triggers and the possibility of re-traumatization for one (1) of two (2) residents reviewed with PTSD. Resident # 41 Findings Include Review of the facility policy titled, Trauma Informed Care with no revision date revealed under, Purpose .To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. Record review of Resident #41's Admission Record revealed the resident was readmitted to the facility on [DATE] with medical diagnoses that included Post Traumatic Stress Disorder (PTSD) and Bipolar Disorder. Record review of Resident #41's Care Plan Detail revealed under, Focus: Resident has a dx (diagnosis) of PTSD related to killing other humans with a machine gun in combat. Resident has experienced other trauma such as death of close family, being assaulted in lifetime . Under Interventions/Tasks, the care plan was not developed for triggers or trigger-specific interventions. During an interview on 3/12/25 at 8:35 AM, Resident #41 confirmed that he does have PTSD that stems from when he came home from Vietnam and the treatment that he received during the war. In an interview on 3/12/25 at 8:50 AM, Certified Nurse Assistant (CNA) #5 revealed she had no idea if Resident #41 had PTSD. In an interview on 3/12/25 at 9:40 AM, the Social Worker (SW) confirmed that Resident #41 did have PTSD, but that she didn't know what his triggers were and had never discussed his PTSD or triggers with him. During an interview on 3/12/25 at 10:00 AM, the Director of Nurses (DON) confirmed that Resident #41's plan of care did not address any triggers. She stated that she knew what his triggers were, and they included being awakened in the middle of the night by staff knocking on the door and entering the room. She confirmed that since the staff were not made aware of the resident's triggers and interventions to prevent them it could lead to re-traumatization. Record review of Resident #41's MDS revealed an ARD of 1/15/2025 and, in Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 23 sampled residents. Resident #10 Findings include: A review of the facility policy titled, Storage of Medications revised April 2007 revealed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. An observation on 3/11/25 at 10:15 AM revealed Resident #10 had a bottle of Tums Ultra Strength 1000 mg (milligrams)and Equate Nasal Spray 3 fluid (fl) ounces (oz) sitting on his overbed table. An observation and interview on 3/12/25 at 11:10 AM revealed Resident #10's medication of a bottle of Tums Ultra Strength 1000 mg and Equate Nasal Spray 3 fl. oz remained sitting on his overbed table. Resident #10 revealed that he has bad indigestion and needs his medicine and stated, If they come in here and try to take them, I'll walk out right now. A record review for Resident #10 revealed there was no self-administration of medication assessment. During an interview on 3/12/25 at 11:15 AM Licensed Practical Nurse (LPN) #4 revealed she is assigned to Resident #10 and gives him his medicines; she revealed she was not aware that the resident had medicine sitting on the overbed table because she gives him all of his medications and stands there while he takes them. During an observation and interview on 3/12/25 at 11:25 AM LPN #4 confirmed that the resident had medications sitting on his overbed table and revealed he was not supposed to have them. She revealed his family brought these medicines in for him, and she had overlooked them sitting there. In an interview on 3/12/25 at 11:35 AM, the Assistant Director of Nurses (ADON) confirmed that Resident #10 did not have a medication self-administration form filled out and had not been evaluated to self-administer medications. She confirmed the medications were not supposed to be left at the bedside, but all medications were to be kept locked in the medication cart. She revealed with the resident having access to these medications, he could take too much, or someone could wander into his room and take them. A record review of Resident #10's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1 through Stage 4 Chronic Kidney Disease, and Gastro-Esophageal Reflux Disease. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/2024 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #10 has moderate cognitive impairment.

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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. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure dietary staff followed proper hand hygiene practices and monitor food temperatures in a manner that prevented cross-contamination for one (1) of two (2) kitchen tours. Findings Include: Review of the facility policy titled Hand and Single Use Glove Sanitation Practices with a revision date of October 2017, revealed Policy: Facility employees shall follow sanitary practices when handling food to prevent the spread of foodborne illness . Review of the facility policy titled Guidelines for Using Thermometers with a revision date of October 2017, revealed Policy: the facility shall monitor temperatures of hazardous foods to maintain quality and safety of food served using an appropriate thermometer . An observation of the kitchen on 3/12/25 at 11:00 AM revealed Dietary Staff #2, located near the 3-compartment sink, gathering kitchen utensils. He walked over to the steam table with a white dish cloth in his hands and began setting up to check food temperatures. Dietary Staff #2 did not wash his hands before proceeding. After measuring the temperature of the hamburger patties, he picked up the dish cloth from the plate rest and wiped the end of the thermometer probe. He then inserted the thermometer into a pan containing lettuce and tomatoes. After removing the thermometer, he again wiped the probe with the dish cloth, continuing this same process - checking temperatures and wiping the probe with the dish cloth - until all food temperatures were measured. An interview with Dietary Staff #2 on 3/12/25 at 11:16 AM confirmed that he did not wash his hands before checking the food temperatures. He stated, I just had my hands in Clorox water, and acknowledged that this practice could cause cross-contamination of the food. He further explained that it was common practice to use a dish cloth to wipe the thermometer probe between uses, and that this was how he had been trained to do it. Dietary Staff #2 admitted that this could potentially make a resident sick due to cross-contamination from the dish towel to the food. An interview with the Dietary Manager (DM) on 3/12/25 at 11:36 AM confirmed that dietary staff were required to perform hand hygiene before checking food temperatures and anytime they handle food. She explained that the kitchen had disposable wipes that should be used to clean the thermometer probe between uses. The DM acknowledged that improper hand hygiene and improper cleaning of the thermometer could result in cross-contamination and the spread of harmful bacteria to food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health & Rehab LLC	230 River Oaks Drive Canton, MS 39046

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46013 Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Quarter 1 2025 Findings include Record review of facility policy titled, Submission Timeliness and Accuracy dated April 2016, revealed, Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Record review of PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 1 2025 (October 1-December 31), revealed the facility triggered on this report for excessively low weekend staffing. During an interview on 3/11/25 at 11:50 AM, the Administrator revealed I don't understand how we were running excessively low weekend staffing; we were adequately staffed during that time. He revealed we were transitioning between payroll systems then, and maybe it didn't transition accurately. Record review of the facility staffing grid for the weekends of quarter 1 revealed no issues with low weekend staffing. During an interview on 3/13/25 at 9:33 AM, the Human Resources Director revealed that after reviewing the discrepancy of low weekend staffing for the first quarter of 2025, we have determined that all of the nursing hours did not show up accurately. She revealed we were transitioning to a different payroll system, and the hours did not transition over accurately. Therefore, the facility didn't report the required staffing information and ensure it's accuracy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. Building B. Wing	03/13/2025

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, resident representative and staff interviews, record review, and facility policy review, the facility failed to ensure proper catheter care and infection control practices were implemented for one (1) of four (4) residents direct care areas observed (Resident #37). Findings include: A review of the facility policy titled, Catheter Care Urinary, revised September 2014, revealed under Infection Control: b.) Ensure the catheter tubing and drainage bag are kept off the floor. Further review of the policy under Steps in the Procedure revealed: 31.) Use a clean washcloth with warm water and soap or cleansing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward. An observation of Resident #37 and interview with the resident's representative on 3/11/25 at 2:23 PM revealed a catheter bag hanging on the left side of the resident's wheelchair, with the catheter bag and tubing observed resting on the floor. During an interview at that time with the resident's representative, she revealed the resident has a history of frequent urinary tract infections and has the catheter because her bladder does not empty. An observation of catheter care for Resident #37 on 3/12/25 at 10:20 AM revealed upon entrance to the room, the catheter bag and tubing were laying on the floor. Certified Nurse Assistant (CNA)# 6 was observed performing hand hygiene and cleansing the urinary meatus and catheter tubing with a wet washcloth. There was no observation of soap or cleansing products added to the water basin or washcloth. CNA #6 then dried the urinary meatus and catheter tubing with a dry cloth, completed the procedure, and performed hand hygiene. In a concurrent interview, CNA #6 confirmed the catheter bag should not have been placed on the floor. She also acknowledged she cleaned the urinary meatus, perineal area, and catheter tubing using only water without soap or cleansing product. CNA #6 stated she avoided using soap because she did not want to irritate the resident's skin. Record review of the Order Summary Report for Resident #37 revealed an active order dated 1/29/25 to clean urinary catheter with soap and water every shift. During an interview with the Director of Nursing (DON) on 3/12/25 at 11:14 AM, she confirmed the catheter bag should not have been placed on the floor and that staff performing catheter care should have used soap and water to clean Resident #37 as ordered. She stated that placing the catheter bag on the floor and failing to cleanse with soap and water increases the risk of infection for the resident. Record review of Resident #37's Admission Record revealed the resident was admitted on [DATE] with diagnoses including Retention of Urine and Urinary Tract Infection. Record review of Resident #37's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 2/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Section H-Bladder and Bowel was coded as having an indwelling catheter.