STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255275	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Senior Care, LLC	3701 Peter Quinn Drive Jackson, MS 39213

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 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. Based on observation, interviews, record review and facility policy review the facility failed to implement comprehensive care plan by not following physician orders related to the application of compression hose, nurses cleaning and changing tubing on suction device and wearing Personal Protective Equipment (PPE) while providing direct care for three (3) of five (5) care observations. Resident #6, Resident #8, and Resident #22.Findings Include:Record review of the facility policy Comprehensive Care Plans revision date of 10/23 revealed, It is the policy 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 resident's medical, nursing and mental and psychosocial needs, that are identified in the resident's comprehensive care assessment .Resident #6Record review of the Care Plan Report revealed Focus: She has problems with chronic recurring edema to her (B) (bilateral) lower extremities.Intervention.Apply her (B) knee-high compression hose q (every) AM and remove at HS (hour of sleep) per MD orders. On 04/13/26 at 11:20 AM, during an observation and interview, Resident #6 was observed in bed and stated, My legs are swollen and I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch. She pulled the bed covers back and the State Agency (SA) observed her legs were swollen and she had red slip free socks on.On 04/13/26 at 2:13 PM, during an interview and observation with Licensed Practical Nurse (LPN) #1 confirmed that Resident #6 did not have compression hose on. She stated they should be put on daily.On 04/16/26 at 2:40 PM in a phone interview with CNA #1stated Resident #6 stated residents went to bingo at 2:00 PM and the resident did not want the compression hose on. The SA informed CNA #1 that Resident #6 did not go to bingo and that LPN #1, and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond.On 04/14/26 at 2:54 PM, in an interview the Director of Nursing (DON) stated the purpose of compression hose is to decrease swelling and increase circulation through the body. She stated her expectations for CNAs to put hose on in the AM after breakfast.Record review of the admission Record revealed an admission date of 10/14/21 with diagnosis of personal history of other venous thrombosis and embolism and localized edema. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicates the resident is cognitively intact.Record review of the Order Summary Report revealed a physician order dated 8/3/22 Apply bilateral knee-high compression hose every AM (morning) and remove at HS (hour of sleep) every day and night shift for edema.Resident #8Record review of the Care Plan Report revealed Focus: He is at risk for complications related to his use of a feeding tube .Interventions. Observe Enhanced Barrier Precautions when providing care (ie: dressing, bathing, transfers, personal hygiene, changing linen incont (incontinent) care.On 04/15/26 2:32 PM, during an observation of Resident #8 receiving perineal (peri) care revealed CNA#2 provided care without wearing a gown. Resident #8 is on Enhanced Barrier Protection (EBP) due to a percutaneous endoscopic gastrostomy (peg) tube.On 04/15/26 2:46 PM, in an interview with CNA #2, she confirmed she did not wear a gown while providing peri-care. She stated the purpose of the gown to prevent transferring infections to the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. She stated she placed the resident at risk for infection by not wearing a gown.Record review of Resident #8 admission Record revealed an admit date of 5/18/17 with diagnoses that included hemiplegia and hemiparesis, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.Record review of the MDS with an ARD of 4/2/26 revealed a BIMS score of 13 indicating the resident was cognitively intact.On 04/16/26 at 10:48 AM, in an interview the DON stated CNA#2 should have donned (put on) a gown before providing peri care. She stated Resident #8 is on EBP due to the peg tube. She stated staff should wear gowns anytime they are doing high contact care. She stated that peri care is high contact care. She stated her expectation of staff while doing care on residents who are on EBP, is that they give proper and adequate care. She stated CNA #2 placed Resident#8 at higher risk of infection by not wearing a gown.Resident #22Record review of the Care Plan Report revealed .Ensure equipment is cleaned per facility protocol. Ensure equipment is set up and properly working for use. Instruct her to inform staff when she uses the suction machine so that the nurse may document accordingly.On 04/13/26 at 11:28 AM, an interview and observation revealed Resident #22 sitting up in bed watching TV. Resident #22 had suction set up on the bedside table. She stated, I have swollen issues and suction myself. The yankauer is dated 9/15/25, the yanker and tubing were dingy yellow, cloudy.On 04/14/26 10:19 AM in an interview and observation of Resident #22 with LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse's responsibility to change tubing and yankauer, not the family.On 04/14/26 at 10:26 AM, an interview the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 is our resident and our responsibility. She stated, we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly. She stated family doing it could cause the resident to get a respiratory infection.On 04/14/26 at 10:30 AM, in an interview and observation in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. On 04/14/26 at 12:10 PM, in an interview the DON stated they do not have assessment of Resident #22's ability to properly perform self-oral suctioning. She stated they should have completed one to make sure she can suction correctly and safely.On 04/16/26 at 9:28 AM, during a phone interview with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows he does it. On 04/16/26 at 10:53 AM, in an interview the DON stated care plans are individualized. She stated it informs the staff of the care residents require and they should follow it. She stated CNA #1, #2, and nurses did not follow care plan.On 04/16/26 at 11:03 AM, in an interview with Registered Nurse (RN)# 1/MDS nurse stated the care plan is used by all staff to give care. She stated she expects staff to use it while providing care. She stated staff can't give adequate care if they do not follow care plan.Record review of Resident #22's admission Record revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease.Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's Order Summary Report revealed an order dated 11/17/25 Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed Resident may suction self as needed (PRN) due to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	increased salivation. Resident may use suction independently.Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interviews, record review and facility policy review the facility failed to follow physician orders, as evidenced by not applying compression hose for a resident and not cleaning suction equipment for two (2) of (2) residents reviewed. Resident #6 and #22.Findings Include:Record review of the facility policy Provision of Quality Care dated 2025, revealed, Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice.Each resident will be provided with care and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being . Resident #6During an observation and interview on 04/13/2026 at 11:20 AM, Resident #6 was observed in bed and stated, My legs are swollen and I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch. She pulled the bed covers back and the State Agency (SA) observed her legs were swollen and she had red slip free socks on.During an interview and observation on 04/13/2026 at 2:13 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #6 did not have compression hose on. She stated they should be put on daily.In a phone interview on 04/16/2026 at 2:40 PM, CNA #1 stated Resident #6 went to bingo at 2:00 PM and the resident did not want the compression hose on. The SA informed CNA #1 that Resident #6 did not go to bingo and that LPN #1, and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond.Record review of the admission Record revealed an admission date of 10/14/21 with diagnosis of personal history of other venous thrombosis and embolism and localized edema. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicates the resident is cognitively intact.Record review of the Order Summary Report revealed a physician order dated 8/3/22 Apply bilateral knee-high compression hose every AM (morning) and remove at HS (hour of sleep) every day and night shift for edema.Resident #22During an interview and observation on 04/13/2026 at 11:28 AM, revealed Resident #22 sitting up in bed watching TV. Resident #22 had suction set up on the bedside table. She stated, I have swollen issues and suction myself. The yankauer is dated 9/15/25, the yanker and tubing were dingy yellow, cloudy.During an interview and observation with Resident #22 on 04/14/2026 10:19 AM, LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse's responsibility to change tubing and yankauer, not the family.During an interview on 04/14/26 at 10:26 AM, the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 is our resident and our responsibility. She stated, we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly. She stated family doing it could cause the resident to get a respiratory infection.During an interview and observation on 04/14/26 at 10:30 AM, in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. During an interview on 04/14/26 at 12:10 PM, the DON stated they do not have an assessment of Resident #22's ability to properly perform self-oral suctioning. She stated they should have completed one to make sure she can suction correctly and safely.During a phone interview on 04/16/26 at 9:28 AM, with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility knows he does it. During an interview on 04/16/2026 11:08 AM, Registered Nurse #1 (RN)/MDS stated a nurse is supposed to assess Resident #22 to make sure she can suction herself.Record review of Resident #22's admission Record revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease.Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's Order Summary Report revealed an order dated 11/17/25 Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently.Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure accurate and complete submission of staffing data through the Payroll-Based Journal (PBJ) system to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) FY (fiscal year) quarters reviewed. This deficient practice had the potential to result in inaccurate public reporting of staffing levels and misrepresentation of the facility's actual staffing, including the omission of contract nursing staff hours. Findings included:Record review of the facility policy titled Payroll Based Journal, dated 2025, revealed It is the policy of this facility to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .During an interview on 04/16/2026 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA) stated he is responsible for compiling and submitting PBJ data to the CMS portal. He stated employee staffing data is received from the corporate office through a software generated file and used for PBJ submission. He stated contract nursing staffing data is received separately from vendors and manually entered into the PBJ system. The LNHA stated he was not aware of any errors in the PBJ data submitted for the first quarter and provided documentation supporting the submitted data. Upon further investigation, the LNHA stated the data transmitted from the corporate software system was not accurately submitted to the CMS PBJ system. He confirmed contract nursing staffing data for 10/25/2025, 11/22/2025, 12/06/2025, 12/19/2025, 12/27/2025, and 12/28/2025 was not included in the PBJ submission.Record review of PBJ submission documentation confirmed contract nursing staffing hours for the identified dates were not included in the data submitted to CMS.Record review of the PBJ Staffing Data Report for FY (Fiscal Year) Quarter 1 2026 (October 1-December 31) revealed This staffing Data Report identifies areas of concern that will be triggered.Excessively Low Weekend Staffing.During an interview on 04/14/2026 at 1:15 PM, the LNHA confirmed the facility utilized contract nursing staff.During an interview on 04/16/2026 at 11:00 AM, the Director of Nursing (DON) stated she and the Staffing Coordinator are responsible for staffing. She stated staffing is based on resident acuity and the facility assessment. She stated Unit Supervisors may adjust schedules to maintain coverage. She confirmed the current schedule supports a census of 55 residents and call outs are managed without staffing issues.Record review of staffing schedules and daily staffing sheets revealed no staffing shortages or concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, record reviews and facility policy review the facility failed to prevent the possibility of spreading infection as evidenced by not wearing proper personal protective equipment (PPE) and not adhering to Enhanced Barrier Precautions (EBP) during high contact care, not performing hand hygiene prior to care and not protecting a yankeaer from bacteria, changing tubing, and cleaning a suction device for three (3) of five (5) care observations. Resident# 8, Resident #22 and Resident #49.Findings include:Record review of the facility policy Hand Hygiene Policy dated 2025 revealed, Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors . Before performing residents care procedures.Record review of the facility policy Enhanced Barrier Precautions dated 2025 revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities.Resident #8On 04/15/2026 at 2:32 PM, during an observation Resident #8 received peri care from Certified Nursing Assistant (CNA) #2. Resident #8 had a percutaneous endoscopic tube (peg) tube and was on EBP. Resident #8 had a bowel movement. CNA did not have a gown on as she was performing perineal (peri) care.On 04/15/2026 at 2:46 PM, in an interview with CNA #2 she confirmed she did not have a gown on while providing peri care. She stated the purpose of the gown to prevent transferring infections to the resident. She stated she placed resident at risk for infection by not wearing a gown.On 04/16/2026 10:48 AM, in an interview with the Director of Nursing (DON) stated CNA#2 should have donned (put on) a gown before doing peri care. She stated Resident #8 is on EBP due to the peg tube. She stated staff should wear gowns anytime they are doing high contact care. She stated her expectation of staff while doing care on residents who are on EBP, is that they give proper care and adequate care. Peri care is high contact care. She stated CNA #2 placed the resident at higher risk for infection by not wearing a gown.Record review of Resident #8 admission Record revealed an admit date of Hemiplegia and Hemiparesis' following unspecified Cerebrovascular Disease affecting left non-dominant side, Personal History of Transient Ischemic attack (TIA) and Cerebral Infarction without residual deficits and Dysphagia unspecified.Record review of Resident #8 Minimum Data Set (MDS) Assessment Reference Date 4/2/26 with a Brief Interview of Mental (BIMS) score of 13, which indicates cognitively intact. Section GG reveals he is dependent on hygiene.Resident #22On 04/13/2026 at approximately 11:28 AM in an interview and observation of Resident #22 sitting up in bed watching TV. Resident #22 has suction set up on the bedside table. Resident #22 picks up canker and uses tip of canker to turn it on and then placed canker in her mouth to suction. The canker was on the bed exposed to bacteria. There was no covering or shield to protect it from bacteria. After suction she uses the tip to turn it off and places it on her bed not enclosed in a zip lock bag. During the interview and observation Resident #22 uses canker to suction three times each time using the tip to turn suction on and off. The canker is dated 9/15/25, the canker and tubing are dingy yellow, cloudy.On 04/13/26 at 2:30 PM, during an observation of Resident #22 suctioning herself revealed she used same technique that she had used the previous time.On 04/13/26 at 2:52 PM, during an observation of Resident #22 suctioning herself and placing the yankeaer on bed. She continued to use the of exposed canker to turn it on and off as she used it.On 04/14/2026 10:19 AM in an interview and observation of Resident #22 with LPN #1 confirmed the tubing is dated 9/15/25. She stated Resident #22 son-in- law comes and changes the yankauer and tubing every evening. She stated the coloring of the tube normally looks like that. She stated it comes that way. She confirmed it is the nurse's responsibility to change tubing and yankauer, not the family.On 04/14/26 at 10:26 AM, an interview the Director of Nurses (DON) stated she was not aware of the son-in-law coming and changing the tubing and cleaning the machine. She stated it is the nurse's responsibility to change yankauer weekly and clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the machine on night shift. She stated the family is not supposed to change tubing, yanker or clean it. She stated it should be in a bag to prevent infection and cross contamination. She confirmed it is on the Electronic Medication Administration Record (EMAR,) and nurses are signing off on it. She stated it is not the family's responsibility to change the tubing or clean it. She stated Resident #22 is our resident and our responsibility. She stated, we don't know if the family uses gloves or how they clean the machine or if they are doing it correctly. She stated family doing it could cause the resident to get a respiratory infection.On 04/14/26 at 10:30 AM, in an interview and observation in the room of Resident #22 with the DON, she confirmed the date and discoloration of the tubing. Resident#22 stated my son in law comes every evening and changes the tubing and cleans it. On 04/16/26 at 9:28 AM, during a phone interview with Resident #22's son- in- law, he confirmed that he does the care for resident suction machine. He stated he washes the machine and the tubing out daily. He stated he does not change out tubing he only washes it out daily. He stated the facility knows he does it. Record review of Resident #22's admission Record revealed an admission date of 1/27/25 with diagnoses including Myasthenia Gravis and Dysphagia following Cerebrovascular Disease.Record review of the MDS with an ARD of 2/4/26 revealed a BIMS score of 15 indicating the resident is cognitively intact. Record review of Resident #22's Order Summary Report revealed an order dated 11/17/25 Change canker to suction weekly on the PM (night) shift. May change tubing if visibly unable to flush particles. An order dated 9/10/25 revealed Empty suction nightly and rinse with tap water. An additional order dated 1/28/25 revealed Resident may suction self as needed (PRN) due to increased salivation. Resident may use suction independently.Record review of the EMAR for April 2026 revealed nurses' signatures indicating they changed the tubing and cleaned the suction machine.Resident #49On 04/15/2026 at 2:10 PM, during an observation of CNA #2 revealed she entered Resident #49's room and pulled gloves from the box and donned (put on) them. CNA#2 assisted the resident to the bed, removed his pants and shoes. She then removed her gloves and exited the room. On 04/15/2026 at 2:23 PM, CNA #2 returned to Resident #49's room and put on gloves. She retrieved peri wipes out of the drawer with gloves on. She provided peri care for Resident #49. She did not perform hand hygiene prior to either of the care observations. On 04/15/2026 at 2:43 PM, in an interview with CNA #2 she confirmed that she did not wash or sanitize her hands either time she entered the room to provide care to Resident #49. She stated I sanitized my hands in the hallway before entering the room. She stated Resident #49 could get infection from her not performing hand hygiene.On 04/16/2026 at 10:43 AM, in interview with the Director of Nursing (DON) confirmed CNA #2 should have washed her hands before and after care and that she should have changed gloves after opening the drawer to get peri wipes. She stated CNA #2 placed the resident at increase for infection.Record review of Resident #49 admission Record revealed an admission date of 3/17/2017 with diagnoses that included Parkinson disease with dyskinesia, with fluctuations and urinary tract infection.Record review of Resident #49's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Section GG revealed Resident #49 is dependent on hygiene.On 04/16/2026 12:16 PM, in an interview with RN #2/ Infection Preventionist (IP) nurse stated that CNA #2 should have performed hand hygiene upon entry before starting peri care on Resident #8. She stated Resident #8 could get an infection by CNA #2 giving care without a gown in place. She stated the resident is on EBP due to a peg tube. She stated Resident #22 yankeaer should have been in a bag to prevent contamination tubing should have been changed and device should have been cleaned by nurse. She stated Resident #22's yankeaer should have been placed in a bag to prevent cross contamination. She stated that Resident #22 was put at risk for a mouth or bacterial infection or bacterial infection. She stated Residents #8, #22 and #49 were all placed on higher risk for infection.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, record review and facility policy review the facility failed to honor residents' rights as evidenced by posting of personal signage in the resident's room for one (1) of (14) residents reviewed. Resident #6.Findings Include: Record review of the facility's Resident Rights Policy dated 2025 revealed the facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the facility's responsibility to provide proper care to residents.On 04/13/2026 at 11:20 AM, during an observation and interview revealed Resident #6 was in bed. Observed signage on the wall Please put on compression hose daily even when resident is in bed. They are to be removed every night at bedtime Resident #6 stated, my legs are swollen, I do not have my compression hoses on yet. My Certified Nursing Assistant (CNA) will come to put them on after lunch. Resident #6 pulled her bed covers back and her legs were swollen. She had red slip free socks on. She stated the facility put that sign on the wall and stated, I guess it is to remind them to do it, but they still don't.On 04/13/2026 at 2:13 PM, during an interview and observation with Licensed Practical Nurse #1 (LPN) of the h on the signage on the wall. She stated the signage on the wall is to notify the CNAs to put on the compression hose. She confirmed the CNAs have a Kardex and the task pops up daily to remind them. She confirmed that Resident #6 did not have them on. She stated they should be on daily.On 04/14/26 at 2:54 PM, in an interview with Director of Nursing (DON) stated the signage posted in the room is a dignity issue. She stated it should not be on the wall. She stated CNAs should have placed compression hose on in the morning. She stated the reminder for the CNA shows up in task. She stated that it is their reminder. She stated the purpose of compression hose is to decrease swelling and increase circulation through the body. She stated her expectations for CNAs to put hose on in the morning after breakfast.On 04/16/2026 at 2:40 PM, in a phone interview with CNA #1 stated Resident #6 went to bingo at 2:00 PM and did not want them on. The State Agency (SA) informed CNA #1 that Resident #6 did not go to bingo, that LPN #1 and the SA was in an interview and observation with her at 2:13 PM. CNA #1 did not respond.Record review of the admission Record revealed Resident #6 was admitted to the facility on 10 /14/21 with diagnoses that included personal history of other venous thrombosis and embolism and localized edema. Record review of Resident #6 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/26 revealed a Brief Interview for Mental Status (BIMS) of 13 which indicated the resident was cognitively intact.Record review of the Order Summary Report revealed apply bilateral knee-high compression hose every AM and remove at sleep every day and night shift for edema.