STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255285	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Place	116 Lake Vista Place Brandon, MS 39047

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. 47873 Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident's right to a dignified existence related to a urinary catheter drainage bag that did not have a privacy covering for one (1) of three (3) residents reviewed for catheters. (Resident #16) Findings included: A review of the facility's policy, Resident Rights, undated, revealed, .Policy Interpretation and Implementation .1. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to: a. a dignified existence . On 01/14/2025 at 8:12 AM, during an observation, Resident #16 was in bed and there was a catheter drainage bag that was positioned on the right-hand side of the bed facing the door, with no privacy cover. The urine in the drainage bag was visible from the open door. On 01/14/2025 at 12:31 PM, during an observation, Resident #16 remained in bed. The urinary drainage bag remained uncovered with yellow urine visible. There was no privacy covering for the drainage bag. On 01/14/2025 at 12:32 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated he was responsible for Resident #16's care. He explained that a collection bag cover ensures others cannot see the contents of the bag, maintaining the resident's dignity. CNA #1 confirmed the resident did not have a privacy covering on the drainage bag and he immediately retrieved one for the resident. On 01/14/2025 at 2:14 PM, during an interview, Licensed Practical Nurse (LPN) #1 confirmed that Resident #16's urinary drainage bag lacked a privacy cover. She stated the catheter bag should always have a privacy cover, per facility policy, to ensure dignity and prevent the collection bag and tubing from contacting the floor. On 01/16/2025 at 1:27 PM, during an interview, the Assistant Director of Nursing (ADON) stated his expectation was that all nursing staff ensure urinary catheters are managed per facility policy. He emphasized that catheter bags should always have privacy covers to maintain dignity. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Admission Record revealed the facility admitted Resident #16 on 11/04/2024 with diagnoses including Pressure Ulcer of Sacral Region, Unspecified Stage. A record review of the Order Summary Report with active orders as of 1/16/2025 revealed a physician's order, dated 09/03/2024, to change the suprapubic (indwelling) catheter on the third (3rd) of each month and as needed. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2024 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48669 Based on observation, interviews, record review, and facility policy review the facility failed to accommodate the needs and preferences of residents who required adaptive equipment to take a shower for (1) of (23) sampled residents. Resident #1. Findings Include: A review of the facility policy, Resident Rights,, undated, revealed, Policy Statement .Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to .h. be supported by the facility in exercising his or her rights . On 1/14/25 at 10:38 AM, during an interview with Resident #1, he revealed that he would like to take a shower from time to time. He indicated that he was told there is no shower chair available for him, so he has to rely on bed baths. On 1/15/25 at 9:41 AM, Certified Nursing Assistant #2 (CNA) explained that he has cared for the resident over the past six months. He explains that the facility does not have a shower chair to accommodate his request for a shower but does provide the resident with a bed bath daily. On 1/16/25 at 10:45 AM, in a phone interview with the mother and Resident Representative (RR), she revealed that a couple of months ago she shared her concern about her son, Resident #1, wanting a shower with the Director of Nursing (DON) and the Administrator. She explained that she was told they would look into getting a bariatric shower chair for him, like the one he had at their old building. On 1/16/25 at 11:20 AM, in an interview, the Director of Rehabilitation recalled that Resident #1 was evaluated, and it was concluded that, due to his poor upper trunk control, taking showers would not be safe. He mentions that there may be a special chair available for him somewhere with an outside supplier, but he does not know of one. On 1/16/2025 at 11:37 AM, in an interview with the Administrator, he explained that at the facility's previous building, Resident #1 had a chair he could use for showering. However, it was old, and the decision was made not to bring it to the new building during the move. The Administrator confirmed that Resident #1 should be able to shower whenever he wishes and have the necessary equipment to do so. On 1/16/2025 at 12:01 PM, during an observation and follow-up interview with the Director of Rehabilitation, the facility's current shower chair was inspected. The Director of Rehabilitation indicated that it could be possible, with further evaluation and additional staff assistance, for Resident #1 to use the current shower chair. A review of the Admission Record reveals the facility admitted Resident #1 on 1/15/1996 with diagnosis including Hemiplegia and Hemiparesis. (continued on next page)

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F 0558 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 12/6/24 revealed Resident #1 had a Brief Interview Mental Score (BIMS) of 15, indicating the resident was cognitively intact.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48669 Based on record review, interview, and facility policy review, the facility failed to ensure advance directives were completed and readily available on the charts for seven (7) of twenty-three (23) residents reviewed for advance directives. (Residents #1, 28, 29, 30, 31, 34, and 43) Findings included: A review of the facility policy titled Advance Directives, undated, revealed, Policy Statement: Advance directives will be represented in accordance with state law and facility policy. Policy Interpretation and Implementation . 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record . A record review of the medical records for Residents #1, 28, 29, 30, 31, 34, and 43 revealed there was no documentation regarding information as to whether or not the resident had executed an advance directive. A record review of the Admission Record revealed the facility admitted Resident #1 on 01/15/1996 with diagnoses including Hemiplegia and Hemiparesis, Resident #28 on 07/09/2019 with diagnoses including Parkinson's Disease, Resident #29 on 11/21/2014 with diagnoses including Hemiplegia and Hemiparesis, Resident #30 on 03/23/2015 with diagnoses including Hemiplegia, Resident #31 on 05/14/2015 with diagnoses including Hypertension, Resident #34 on 01/06/2016 with diagnoses including Hemiplegia and Hemiparesis, and Resident #43 on 09/03/2021 with diagnoses including Hypertension. On 01/15/2025 at 12:15 PM, during an interview, the Admissions Director revealed that many of the residents who had been in the facility for a significant amount of time did not have written documentation of their decision to formulate or not formulate an advance directive readily available in their charts. She stated that this documentation was likely in their admission files, which were currently stored in the facility's storage area. On 01/15/2025 at 4:23 PM, during an interview, the Administrator confirmed that advance directives were not readily available in residents' charts. He stated this might be a training issue regarding the execution of all aspects of the advance directive requirements.

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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. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that a resident was free from a physical restraint imposed for staff convenience related to fall prevention for one (1) of 23 sampled residents. Resident #52. Findings included: A review of the facility's policy titled Use of Restraints, revised April 2017, revealed, .Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience or the prevention of falls . On 01/14/25 at 09:05 AM, during an observation, Resident # 52 was sitting in a wheelchair with a lap table secured to the wheelchair. On 01/14/25 at 12:23 PM, during an observation of the lunch meal in the dining room, Resident #52 did not have the lap tray attached to her wheelchair. Her posture was stable, and she was not leaning during the meal. A Certified Nurse Aide (CNA) attached a lap tray to Resident #52's chair before she was transported out of the room. On 01/16/2025 at 3:11 PM, during an interview, CNA #3 who is the Lead CNA, stated the lap tray was used to prevent Resident #52 from falling. She explained that when the resident became agitated, she would beat on the lap tray and yell for help. She stated the lap tray was removed every 15 minutes and when the resident needed toileting. She also noted that most falls occurred on the 3:00 PM to 11:00 PM shift when it was hard to monitor the resident. She added that CNAs did not document lap tray removal every 15 minutes, as it was the nurse's responsibility. On 01/16/2025 at 3:30 PM, during an interview, CNA #4, who cared for Resident #52 on the 3:00 PM to 11:00 PM shift, stated she only released the lap tray when the resident needed to use the bathroom. She reported the resident had the lap tray on pretty much all the time during her shift. CNA #4 was unaware of the reason for the lap tray but noted she had been told the resident had a history of falls. On 01/16/2025 at 3:35 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated that before the lap tray was implemented, Resident #52 had required one-on-one (1:1) supervision. She explained that the lap tray was used to prevent the resident from falling and that CNAs were supposed to release it every two hours, as documented on the Electronic Medication Administration Record (EMAR). She also noted that the resident had fallen twice in recent months, including once with the lap tray in place. On 01/16/2025 at 3:45 PM, during an interview, the Assistant Director of Nursing (ADON) stated the lap tray was used for safety due to Resident #52's history of falls and attempts to get out of her chair. He acknowledged that the resident had fallen with the lap tray in place and that without the lap tray, the facility would be unable to prevent her from falling. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Admission Record revealed the facility admitted Resident #52 on 08/09/2022 and she had current diagnoses including Parkinson's Disease. A record review of the Order Summary Report with active orders as of 1/16/2025, revealed Resident #52 had a physician's order, dated 5/20/2024, for a lap tray when in wheelchair, during waking hours, release every two hours for repositioning and activities of daily living (ADL) care. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/2024 revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severe cognitive impairment. A record review of Resident #52's Lap Tray Checklist, dated 12/18/2024 to 01/16/2025, revealed the lap tray was not documented as being removed every two hours per the physician order. A record review of Resident #52's Initial Assessment for Application of Restraint, dated 05/14/2024, revealed a history of over 20 falls with head contusions and unsafe attempts to ambulate. A record review of Resident #52's Physical Restraint Consent, dated 06/10/2024, indicated the use of the lap tray for safety. A record review of Resident #52's Restraints Physical Quarterly/Annual Evaluation, dated 11/18/2024, indicated the use of restraints was due to unsteady gait, agitated behavior, aggressive behavior, frequent falls, and attempts to self-transfer.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to provide nail care to a diabetic resident requiring nail care by a Registered Nurse (RN) for one (1) of 23 residents whose nails were observed. Resident #31. Findings included: A review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, undated, revealed, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal hygiene . On 01/14/2025 at 8:29 AM, during an observation, Resident #31 was seated in his wheelchair in his room. His fingernails were noted to be long, dirty, and jagged. On 01/15/2025 at 12:21 PM, during an observation in the dining room, Resident #31 was seen eating lunch. His fingernails remained long, dirty, and jagged. On 01/16/2025 at 12:28 PM, during an interview, the Assistant Director of Nursing (ADON) stated that two Registered Nurses are responsible for providing diabetic nail care. He explained that residents' nails are supposed to be cleaned and cut weekly. On 01/16/2025 at 12:32 PM, during an interview and observation, the ADON examined Resident #31's fingernails. He confirmed that the nails on Resident #31's left hand were dirty and needed to be cleaned. He stated that one hand was clean while the other was not. The ADON acknowledged that nails should not be cut too short but expressed his expectation that nurses clean and cut residents' nails weekly. A record review of the Admission Record revealed the facility admitted Resident #31 on 5/14/2015 and he had current diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia. A record review of Resident #31's Order summary Report with active orders as of 1/16/2025 revealed a physician's order, dated 12/4/24, for diabetic nail care to be provided by a Registered Nurse (RN) every Wednesday and as needed. A record review of Resident #31's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/2024 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident was mildly cognitively impaired. Section GG was coded as dependent for personal hygiene. A record review of the January 2025 Electronic Treatment Administration Record (ETAR) revealed the RN staff did not document that diabetic nail care was provided on 01/01/2025 or 01/15/2025.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47873 Based on observation, staff interview, record review and facility policy review the facility failed to prevent possible complications related to a resident with an indwelling suprapubic catheter, as evidenced by the catheter drainage bag coming into direct contact with the floor for one (1) of 1 resident reviewed with a catheter. Resident #16 Findings included: A review of the facility's policy, Catheter Care, Urinary, undated, revealed, .The purpose of this procedure I to prevent catheter-associated urinary tract infections .Infection Control .7 Be sure the catheter tubing and drainage bag are kept off the floor . During an observation on 01/14/2025 at 8:12 AM, Resident #16 was in bed and there was a catheter drainage bag that was positioned on the right-hand side of the bed facing the door. The drainage bag was touching the floor. During an observation on 01/14/2025 at 12:31 PM, Resident #16 remained in bed. The urinary drainage bag remained touching the floor in the room. During an interview on 01/14/2025 at 12:32 PM, Certified Nursing Assistant (CNA) #1 stated he was responsible for Resident #16's care. He explained that a drainage bag privacy cover prevents it from contacting the floor directly, reducing the risk of contamination. During an interview on 01/14/2025 at 2:14 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #16's urinary drainage bag should not be on touching the floor as per the facility's policy. During an interview on 01/16/2025 at 1:27 PM, the Assistant Director of Nursing (ADON) stated his expectation was that all nursing staff ensure urinary catheters are managed per facility policy. He emphasized that catheter drainage bags and tubing must be positioned to prevent contact with the floor. A record review of the Admission Record revealed the facility admitted Resident #16 on 11/04/2024 with diagnoses including Pressure Ulcer of Sacral Region, Unspecified Stage. A record review of the Order Summary Report with active orders as of 1/16/2025, revealed Resident #16 had a physician's order, dated 09/03/2024, to change the suprapubic (indwelling) catheter on the third (3rd) of each month and as needed. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/2024 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41680 Based on observation, staff interview and record review, the facility failed to prevent possible complications related to the storage of a Continuous Positive Airway Pressure (CPAP) mask, for one (1) of two (2) residents reviewed for respiratory. Resident #47 Findings included: On 1/14/2025 at 8:49 AM, during an interview, Resident #47 stated she uses her CPAP machine nightly. She explained that the mask had never been stored in a designated bag and was left on top of the dresser by her bedside. On 1/15/2025 at 12:08 PM, during an observation, Resident #47 was eating lunch in her room, and her CPAP mask remained on the table without being stored in a bag. On 1/15/2025 at 2:32 PM, during an interview, Licensed Practical Nurse (LPN) #1 confirmed that the mask was not in a designated storage bag on 1/14/2025 or 1/15/2025. She stated the mask should be stored in a bag to prevent it from getting dirty and causing complications. On 1/15/2025 at 4:15 PM, during an interview, Registered Nurse (RN) #1, the Infection Preventionist, stated the mask should always be stored in a bag to prevent the resident from acquiring an infection. On 1/15/2025 at 4:18 PM, during an interview, the Assistant Director of Nursing (ADON) stated the CPAP mask should be stored in a bag when not in use. He explained the bag should be labeled with the date, and the mask should be cleaned weekly, placed in a clean bag after cleaning, and the bag replaced weekly to prevent infection. A record review of the Admission Record revealed the facility admitted Resident #47 on 2/28/2023 with diagnoses including Obstructive Sleep Apnea. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/2024 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Record review of the Order Summary Report with active orders as of 1/16/2025 revealed an order dated 1/15/2025 for CPAP Machine Mask to be placed in bag after each use daily.

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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. 47873 Based on observation, staff interview, and facility policy review, the facility failed to ensure medications and a medication cart were locked and secured for one (1) of three (3) medication carts observed. Findings included: A review of the facility's policy, Medication Labeling and Storage undated, revealed, .The facility stores all medications and biologicals in locked compartments . A review of the facility's policy, Administering Medications, undated, policy revealed, .Medications shall be administered in a safe and timely manner as prescribed. Policy Interpretation and Implementation .During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide .No medications are to be kept on top of the cart. The cart must be clearly visible to personnel administering medications, and all outside surfaces must be inaccessible to residents or others passing by . On 01/14/2025 at 7:40 AM, during an observation, an unattended, unlocked medication cart was noted with an unlabeled white tablet in a medication cup left on top of the cart. The cart remained unattended for approximately three (3) minutes. On 01/14/2025 at 8:00 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated that she had pulled a medication for a resident and then walked away from her medication cart to respond to another resident, leaving the cart unlocked and out of her sight. She confirmed this action was a safety issue and could lead to potential medication errors. On 01/16/2025 at 1:27 PM, during an interview, the Assistant Director of Nursing (ADON) stated his expectation during medication administration and storage was that no medications be left on top of carts without full nursing supervision. He also stated that all carts should be locked when not attended by licensed staff. The ADON noted that a resident could access the cart or medications.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 50751 Based on staff interview and the Facility Assessment review, the facility failed to ensure all required elements were included in the Facility Assessment, including specific staffing needs by shift, a plan for recruitment and retention of staff, and contingency planning that do not require activation of the facility's emergency plan for three (3) of (3) days of survey. Findings Included: A record review of the facility's Facility Hierarchy (Facility Assessment), signed 7/1/2024, revealed the Plan for average daily schedule of direct care staff to meets in 24-hour period was three (3) Registered Nurses (RNs), seven (7) Licensed Practical Nurses (LPNs), and 17 Certified Nurse Aides (CNAs). The assessment did not indicate specific staffing needs for each shift, based on changes to its resident population. Further review revealed the Facility Assessment did not include any information or plans regarding staff recruitment and retention, and did not include contingency plans for events that do not require the emergency operations plan to be activated. On 1/16/2025 at 5:01 PM, during an interview with the Administrator, he confirmed the Facility Assessment did not break down the facility's needs regarding staffing based on the different shifts, time of day, needs of the residents. He also confirmed it did not address a plan for recruitment and retention of staff or address contingency plans for events that do not require activation of emergency operations. He stated that he completed a form or template every year and had completed this one in July 2024 prior to the revision of the regulations that occurred in August of 2024.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41680 47873 50751 Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper hand hygiene when a Licensed Practical Nurse (LPN) did not wash her hands or change her gloves during Percutaneous Endoscopic Gastrostomy (PEG) care for one (1) of (1) resident reviewed for care. Resident #22. Findings included: A review of the facility's policy titled Wound Care undated, revealed, .Steps in the Procedure .Wash and dry your hands thoroughly . Loosen tape and remove dressing. Discard soiled dressing and gloves into appropriate receptacles. Wash and dry your hands thoroughly. Put on gloves . On 01/15/2025 at 3:46 PM, during an observation of PEG site care and interview with LPN #2 revealed LPN #2 did not change gloves throughout the procedure. LPN #2 used the same gloves to remove the soiled dressing, cleanse the site, and pat the site dry. LPN #2 confirmed that she did not change gloves during the procedure and acknowledged that gloves should have been changed between removing the soiled dressing and cleaning the site. On 01/16/2025 at 9:55 AM, during an interview, Registered Nurse (RN) #1, the Infection Preventionist (IP), stated that LPN #2 should have changed her gloves multiple times during the procedure. RN #1 explained that gloves should be changed when removing the old dressing, before cleaning the site, and prior to applying a new dressing to reduce the risk of cross-contamination and infection at the PEG tube site. On 01/16/2025 at 10:15 AM, during an interview, the Assistant Director of Nursing (ADON), RN #2, confirmed that gloves should have been changed between removing the old dressing and cleansing the site. RN #2 stated that failure to change gloves could lead to touching a clean site with contaminated gloves, increasing the risk of infection. A record review of the Admission Record revealed the facility admitted Resident #22 on 05/30/2024 with current diagnoses including Gastrostomy Status. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/2024 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired. Further review of the documentation in Section K revealed Resident #22 had a feeding tube (PEG). A record review of the Order Summary Report with active orders as of 1/16/2025, revealed Resident #22 had a physician's order, dated 6/26/24, to clean the PEG site daily.