STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255294	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbough Health and Rehabilitation Center	340 Desoto Ave Extended Clarksdale, MS 38614

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement comprehensive, person-centered care plans to address residents identified Activities of Daily Living (ADL) and skin integrity needs. The facility failed to develop a care plan related to nail care for (Residents #2, #21, and #24); failed to implement the care plan related to grooming and dressing (Resident #21); and failed to develop a care plan related to pressure ulcer prevention (Resident #4) for four (4) of 21 resident care plans reviewed. Findings include: Review of the facility policy titled Comprehensive Care Plan with a review date of 11/14/2025, revealed, Policy: 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 a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Resident #2 On 1/5/2026 at 11:05 AM, during initial rounds Resident #2 was observed lying in bed wearing a hospital gown with approximately one-half of an inch (1/2) in length nails with jagged edges and a thick, brown substance underneath. During an interview on 1/7/2026 at 11:45 AM, the Minimum Data Set (MDS) Coordinator confirmed that the care plan was not developed to include nailcare as part of their daily care. She stated that the care plan is developed and implemented for the resident based on his/her care needs and that nail care should have been included in his care plan. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 1/02/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severely impaired cognition. Resident #4 Record review of the care plan revealed Resident #4 .refused to be turned or repositioned every two (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Actual harm Residents Affected - Few	(2) hours because it interferes with me watching T.V. The care plan did not include interventions to prevent the development of pressure ulcers. Review of the Wound-Weekly Observation Tool, dated 8/18/25, revealed Resident #4 developed a suspected deep tissue Injury (SDTI) to the left (L) heel measuring 60 millimeters (mm) length x 50mm width x 1mm depth on 8/18/25. Record review of the Task List Report revealed the task for off-loading of extremities was not initiated until 12/10/2025. During an interview on 1/6/2026 at 2:15 PM, the MDS Nurse confirmed that the care plan was not developed to include off-loading of extremities to prevent pressure ulcers from developing on the heels. She stated the purpose of the care plan is to guide staff in providing individualized care to residents. On 1/6/2026 at 2:45 PM, during an interview the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that preventative measures were not implemented until 12/10/25. The DON stated her expectation was that preventative measures be implemented prior to the development of pressure ulcers. Record review of the admission Record revealed Resident #4 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Type 2 Diabetes Mellitus with Hyperglycemia, and Peripheral Vascular Disease, Unspecified. Record review of the quarterly MDS with an ARD of 11/10/2025 revealed under Section C a BIMS score of 01, indicating the resident had severely impaired cognition. Resident #21 Record review of Resident #21's Care Plan revealed an ADL self-care performance deficit related to confusion with interventions including extensive assistance of one person physical assist for bathing/hygiene/dressing. On 1/5/2026 at 10:31 AM, during initial rounds Resident #21 was observed lying in bed wearing a hospital gown with a dried, brownish substance on the top right side of the gown, approximately softball-sized, consistent in appearance with food or possible emesis. The resident also had visible scattered dark hair on her chin and long fingernails, approximately three-fourths of an inch (3/4) in length, with jagged edges. During an interview on 1/7/2026 at 2:51 PM, the MDS Coordinator confirmed that the care plan was not developed to include nailcare as part of their daily care nor was the Activities of Daily Living (ADLs) care plan implemented related to grooming and dressing. She further stated the purpose of the care plan is to guide the staff how to best provide care for the residents. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	score of 00, indicating the resident had severely impaired cognition. Resident #24 On 1/5/26 at 11:00 AM, observation of Resident #24 revealed that her fingernails on both hands were approximately one-fourth (1/4) inch past her fingertips and jagged. Record review of Comprehensive Care Plan revealed no nail care plan of care was developed for the trimming and/or cleaning of fingernails. During an interview on 1/7/2026 at 2:51 PM, the MDS Coordinator confirmed that the care plan was not developed to include nail care as part of their daily care. She further stated the purpose of the care plan is to guide the staff how to best provide care for the residents. Record review of the admission Record revealed that the facility admitted Resident #24 on 5/11/24 with a diagnosis of Cognitive Communication Deficit.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and facility policy reviews, the facility failed to ensure the prevention of an avoidable pressure injury for one (1) of seven (7) residents with pressure ulcers, (Resident #4), and delayed treatment for one (1) of seven (7) residents with pressure ulcers. (Resident #58) Findings include: Review of facility policy titled Pressure Injury Prevention and Management, with a review date of 11/7/2025, revealed, Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Resident #4 Review of the Wound-Weekly Observation Tool, dated 8/18/25, revealed Resident #4 developed a suspected deep tissue Injury (SDTI) to the left (L) heel measuring 60 millimeters (mm) length x 50mm width x 1mm depth on 8/18/25. Review of the Wound-Weekly Observation Tool, dated 10/2/25, revealed the SDTI to left (L) heel had progressed to a Stage 3 pressure ulcer measuring 60mm length x 50mm width x 1mm depth, intact and mushy. Review of the care plan revealed Resident #4 .refused to be turned or repositioned every two (2) hours because it interferes with me watching T.V. The care plan did not include interventions to prevent the development of pressure ulcers. Review of the Task List Report revealed the task for off-loading of extremities was not initiated until 12/10/2025 and the wound was identified on 08/18/25 as a SDTI. During an interview on 1/6/2026 at 2:45 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that preventative measures were not implemented until 12/10/25. The DON stated her expectation was that preventative measures be implemented prior to the development of pressure ulcers. Record review of the admission Record revealed Resident #4 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Type 2 Diabetes Mellitus with Hyperglycemia, and Peripheral Vascular Disease, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 01, indicating the resident had severely impaired cognition. Resident #58 Record Review of the Wound-Weekly Observation Tool, dated 9/15/25, revealed Resident #58 developed a Stage II pressure ulcer on sacrum, it is noted to have been identified on 9/13/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record Review of orders to treat were received on 9/15/2025. Registered Nurse (RN) #1 received the physician orders and performed wound care. During an interview on 1/7/2026 at 3:00 PM with RN #1, she stated she was unaware of wound until 9/15/25. This resulted in a two-day delay in physician notification, obtaining treatment orders, and initiation of wound care for Resident #58's Stage II pressure ulcer. During an interview on 1/7/2026 at 4:10 PM, the DON and ADON confirmed that the wound should have been reported, orders obtained and treated the same day the wound was identified and there should not be a delay in treatment. Record review of the admission Record revealed Resident #58 was admitted to the facility on [DATE] with medical diagnoses that included Giardiasis. Record review of the quarterly MDS with an ARD of 9/11/2025 revealed under Section C a BIMS score of 14, indicating no cognitive impairment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure one (1) of 50 residents was treated with dignity when staff allowed the resident to remain in the dining room awaiting the lunch meal without adequate clothing coverage, resulting in exposure of bare skin in a public area. (Resident #31)Findings Include:Review of facility policy titled Promoting/Maintaining Resident Dignity, with a review date of 11/7/2025, revealed, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity.On 1/5/2026 at 11:45 AM, Resident #31 was observed sitting in the dining room waiting for lunch to be served. The resident's pants were down underneath her buttocks, and her bare skin was exposed. When asked about her clothing, she stated she did not know why staff left her in that condition. At the time of the observation, approximately 12 other residents and staff were present in the dining room.During an interview on 1/5/2026 at 11:48 AM, the Assistant Director of Nursing (ADON) confirmed that Resident #31's pants were down past her buttocks and that her bare skin was exposed. She stated this was unacceptable and that residents should not be present in the dining room in that condition. She further confirmed this situation constituted a dignity concern and stated it should never occur. During an interview on 1/6/2026 at 3:40 PM, the Director of Nursing (DON) confirmed her expectation that residents be dressed appropriately while in common areas and that staff are responsible for ensuring residents' clothing is properly positioned to maintain dignity. Record review of the admission Record revealed Resident #31 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction due to Embolism of Unspecified Cerebral Artery.Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 07, indicating the resident had moderately impaired cognition.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure residents received mail on Saturdays for two (2) of 17 residents who attended the Resident Council meeting. (Residents #7 and #8)Findings include:Review of facility policy titled Resident Rights with a review date of 11/14/2025, revealed, .Resident Rights.Information and communication.The resident has the right to send and receive mail.During the Resident Council meeting on 1/7/2026 at 2:15 PM, Resident #7 and Resident #8 stated that mail was not delivered on Saturdays and was distributed only Monday through Friday.During an interview on 1/8/2026 at 9:00 AM, the Director of Nursing (DON) confirmed that resident mail was distributed Monday through Friday only and that mail received on Saturdays was held until the next business day because no staff member was assigned responsibility for mail distribution on weekends.During an interview on 1/8/2026 at 9:14 AM, the Administrator stated he was unaware, until the previous day, that mail was not being delivered on weekends. He confirmed that residents have the right to receive mail on the weekends when mail is delivered by the post office. Record review of the admission Record revealed Resident #7 was admitted to the facility on [DATE].Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Record review of the admission Record revealed Resident #8 was admitted to the facility on [DATE].Record review of the Annual MDS with an ARD of 12/31/2025 revealed under Section C a BIMS score of 15, indicating the resident was cognitively intact.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to ensure required Ombudsman notification was completed and documented when a resident was transferred to the hospital for one (1) of three (3) transfers/discharges reviewed. Resident #55. Findings Included: Record review of the facility policy Transfer and Discharge [including Against Medical Advice (AMA)] revealed 9. Non-Emergency Transfers or Discharges .d. The facility will provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. Record review of a Progress Note for Resident #55 revealed that he was transferred to the hospital on [DATE]. Interview with the Director of Nursing on 1/7/26 at 1:00 PM she stated that there was no documentation of Ombudsman notification of the resident's transfer on 11/25/25 because it was not sent. Interview with the Administrator on 1/7/26 at 1:10 PM, he stated that the Social Worker (SW) was responsible for sending the Ombudsman notifications, however she was on leave during that timeframe. He stated that it was his expectation that Medical Records (MR) personnel would send the notifications to the Ombudsman in the SW absence. Interview with MR personnel on 1/8/26 at 9:05 AM, she stated that she does not recall being assigned to send out Ombudsman notifications while the SW was out.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents who required assistance received grooming and personal hygiene, including nail care (Resident #2, 21 and 24) and cleanliness of clothing (Resident #21) for three (3) of 50 residents observed for activities of daily living (ADLs). Findings Include: Review of facility policy titled Activities of Daily Living (ADLs), with a review date of 11/7/2025, revealed, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. Resident #2 During initial rounds on 1/5/2026 at 11:05 AM, Resident #2 was observed lying in bed wearing a hospital gown with approximately one-half of an inch (1/2) in length nails with jagged edges and a thick, brown substance underneath. During an interview and observation on 1/6/2026 at 10:35 AM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that the Certified Nursing Assistants (CNA)s are responsible for ensuring residents nails are kept clean, and the nurse is responsible for trimming his nails. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/02/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severely impaired cognition. Resident #21 During initial rounds on 1/5/2026 at 10:31 AM, Resident #21 was observed lying in bed wearing a hospital gown with a dried, brownish substance on the top right side of the gown, approximately softball-sized, consistent in appearance with food or possible emesis. The resident also had visible scattered dark hair on her chin and long fingernails, approximately three-fourths of an inch (3/4) in length, with jagged edges. During an observation and interview on 1/5/2026 at 11:38 AM, CNA #1 confirmed Resident #21's gown had a dried, brownish substance on the top right side consistent in appearance with food or possible emesis, visible dark hair on her chin, and long, jagged fingernails. CNA #1 stated that Resident #21 typically had more facial hair than was present at the time, stating, She must have been shaved recently because there are usually lots more. During an interview on 1/6/2026 at 3:53 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that CNAs are responsible for ensuring residents receive assistance, or total care if needed, with ADLs each morning, including bathing or hygiene care as needed, dressing, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and grooming. The DON stated residents should not be left with visible grooming concerns, including soiled clothing, unaddressed facial hair, or long, jagged fingernails. She further stated that long, jagged fingernails pose a potential risk for infection related to skin tears and that wearing soiled clothing and female residents having unwanted facial hair are dignity concerns. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS score of 00, indicating the resident had severely impaired cognition. Resident #24 Observation of Resident #24 on 1/5/26 at 11:00 AM, revealed that her fingernails on both hands were approximately one-fourth (1/4) inch past her fingertips and jagged. Interview with CNA #2 on 1/5/26 at 11:36 AM, she verified that Resident #24 had long jagged nails and she stated that she thought the shower team was responsible for cutting nails. Interview with the DON she stated that the shower aid is responsible for nail care on shower days, but if the resident refused a shower the floor CNA should have cut the nails. She agreed that the nails were long and put Resident #24 at risk for injury. Record review of the admission Record revealed that the facility admitted Resident #24 on 5/11/24 with a diagnosis of Cognitive Communication Deficit.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident responsible party interview, record review, and facility policy review the facility failed to ensure a resident received necessary care and treatment to maintain the highest practicable level of well-being by failing to obtain physician orders for wound dressings identified upon admission (Resident #16) for one (1) of 21 residents reviewed for skin and wound concerns. Findings Include: Review of the facility policy titled Provision of Quality Care with no revision date revealed, Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Resident # 16 Observation on 01/05/26 at 11:45 AM revealed the Resident #16 had an undated dressing located on the left upper arm. Record review of the admission Record revealed the facility re-admitted Resident #16 to the facility on [DATE] with a diagnosis of Acute Respiratory Failure with Hypoxia. Record review of a General Progress Note dated 12/30/25 revealed .Resident has pressure dressing to left upper arm . Record review of December 2025 and January 2026 Order Summary Report revealed no physician order for a dressing or treatment to the resident's left upper arm. Interview with Licensed Practical Nurse (LPN) #1 on 01/05/26 at 11:48 AM, confirmed the dressing was not dated and she was unsure why the dressing was present on the left upper arm of the resident. LPN #1 stated that the resident's family reported the dressing may have been placed there during her recent hospital stay, when staff attempted to start intravenous (IV) fluids. Interview with the Registered Nurse (RN) #1 on 01/05/26 at 11:50 AM, confirmed there were no orders for a dressing to the resident's left upper arm. RN #1 was unsure why the dressing remained in place or how long it had been present. Telephone interview with Resident #16's Resident Representative (RR) on 01/05/26 at 2:08 PM, he confirmed that during a hospitalization in December 2025, prior to re-admission, hospital staff attempted IV access to the resident's left upper arm, which resulted in bleeding and placement of a dressing. Interview with the Director of Nursing (DON) on 01/05/26 at 2:15 PM, she confirmed the dressing should have been removed and the left arm assessed upon admission to determine the condition of the skin and orders obtained for care. The DON stated failure to remove the dressing or assess the resident's arm could have resulted in skin breakdown or infection.

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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. Based on record review, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of seven (7) residents on fluid restrictions. Resident #7. Findings Included: Record review of the facility policy titled Fluid Restriction date reviewed 11/5/25 revealed It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders . Record review of the Order Summary Report for Resident # 7 revealed an active order, dated 7/11/2025 for fluid restriction 1000 cubic centimeters (CC). Total nursing 300cc nursing days, 120cc evening, 90cc night. Total dietary 700cc breakfast, 340cc lunch, 120cc supper -240cc. Record review of Resident #7's January 2026 Electronic Medical Record (Emar) and interview with Registered Nurse #2 (RN) on 1/7/26 at 9:45 AM, she stated that the resident was on a fluid restriction related to being on dialysis. She verified that there was no documentation of Resident #7's intake, but there should be. She agreed that the resident's intake should be monitored and documented to ensure that the fluid restriction is being followed. She stated that it is important to keep up with the resident's intake to ensure the resident did not have fluid overload. Interview with the Director of Nursing (DON) on 1/7/26 at 9:50 AM, she stated that it was her expectation that the nursing staff would monitor and document the intake of a resident who has an order for a fluid restriction. Record review of the admission Record revealed that the facility admitted Resident #7 on 2/24/23 with a diagnosis of End Stage Renal Disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255294	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbough Health and Rehabilitation Center	340 Desoto Ave Extended Clarksdale, MS 38614

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record reviews, and facility policy review, the facility failed to ensure newly prescribed medications were accurately transcribed onto the Medication Administration Record (MAR) for one (1) of five (5) residents reviewed for unnecessary medications. This failure resulted in the resident's antipsychotic medication being abruptly discontinued for 12 consecutive days. (Resident #21)Findings include:Review of facility policy titled Medication Orders, with a review date of 11/7/2025, revealed, .Documentation of Medication Orders.When a new order changes the dosage of a previously prescribed medication, discontinue (DC) previous entry by writing DC'd and the date, or discontinue the order and per the electronic software instructions and retype the new order.Record review of the Psych Progress Notes for Resident #21, dated 11/12/25, revealed, .Recommendations: Decrease Seroquel from 200 milligrams (mg) twice a day (BID) to 200 mg every (q) at bedtime (hs) .Record review of the Psych Progress Notes for Resident #21, dated 11/19/25, revealed, .Recommendations: Decrease Seroquel again - decrease to 50 mg by mouth (PO) every (q) at bedtime (hs) from 200 mg q hs. Record review of the November 2025 MAR revealed Seroquel 200 mg twice daily (BID) was discontinued on 11/12/25; however, the revised order not transcribed until 11/25/2025. According to the November 2025 MAR, Resident #21 did not receive Seroquel from 11/13/25 through 11/24/25.During an interview on 1/8/2026 at 11:24 AM, the Director of Nursing (DON) confirmed that Resident #21's Seroquel was discontinued on 11/12/25 and was not restarted until 11/25/25. She confirmed the psychiatric recommendation dated 11/12/25 was not fully implemented, resulting in the resident abruptly stopping the medication. She stated that abruptly discontinuing an antipsychotic medication could result in adverse effects for the resident. She further stated her expectation was that psychiatric recommendations to be followed in their entirety. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severely impaired cognition.

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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** Based on observations, staff interviews, record review, and facility policy reviews, the facility failed to implement infection prevention and control practices to prevent the transmission of infections. The facility failed to ensure that staff used Enhanced Barrier Precautions (EBP) during medication administration and failed to ensure oxygen delivery devices and wash basins were stored in a sanitary manner when not in use during three (3) of nine (9) resident care opportunities. (Residents #5, #9 and #21) Findings Include:Review of facility policy titled Oxygen Administration with a review date of 11/7/2025, revealed, .Policy Explanation and Compliance Guidelines.Keep delivery devices covered in plastic bag when not in use.Review of facility policy titled Enhanced Barrier Precautions (EBP) with a review date of 11/13/2025, revealed, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.An order for enhanced barrier precautions will be obtained for residents with any of the following:.indwelling medical devices (e.g.feeding tubes.even if the resident is not known to be infected or colonized with a multidrug drug resistant organism (MDRO).Review of facility policy titled Safe and Homelike Environment with a review date of 10/14/2025, revealed, In accordance with residents' rights, the facility will.preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes.equipment used in the completion of the activities of daily living.Resident #5During initial rounds on 1/5/2026 at 10:35 AM, Resident #5's nebulizer mask and Continuous Positive Airway Pressure (CPAP) mask were observed lying uncovered on the bedside table and not stored in a clean, protective bag, creating a risk for contamination of respiratory equipment. During an interview on 1/6/2026 at 3:59 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that all respiratory mask/cannula and tubing should be stored in a plastic bag when not in use. The DON stated that the tubing and masks being left out on the bedside table put Resident #5 at an increased risk for infection and was not an acceptable practice. She further stated that her expectations were that plastic storage bags should always be used when the masks/tubing was not in use. Record review of the admission Record revealed Resident #5 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified, and Hypertensive Heart Disease with Heart Failure. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.Resident #9During medication administration observation on 1/7/2026 at 10:00 AM, with Licensed Practical Nurse (LPN) #3, revealed that LPN #3 failed to follow infection control procedures for EBP during medication administration through Resident #9's feeding tube. LPN #3 confirmed she forgot to wear the gown during medication administration and stated that EBP should have been used due to Resident #9 having a feeding tube to help prevent the possible spread of infection.During an interview on 1/7/26, the DON confirmed that EBP should have been used during medication administration since Resident #9 had a feeding tube used for feeding and medication administration. She verbalized that EBP was to be used as ordered for the prevention of infection.Record review of the admission Record revealed Resident #9 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction, Unspecified. Record review of the quarterly MDS with an ARD of 12/15/2025 revealed under Section C that a BIMS was not assessed.Resident #21During initial rounds on 1/5/2026 at 10:35 AM, observation of five (5) wash basins that were stored directly on Resident #21's bathroom floor, uncovered and not stored in a bag or container. During an interview on 1/7/2026 at 1:55 PM, the Director of Nursing (DON) confirmed that reuseable bath basins should be labeled with the resident's name and stored in a bag or container off the floor for infection control purposes. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical (continued on next page)

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