STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senatobia Healthcare & Rehab	402 Getwell Dr Senatobia, MS 38668

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 - 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** 45598 Based on resident and staff interviews, record review and facility policy review the facility failed to implement a comprehensive care plan for residents with personal hygiene needs for two (2) of six (6) sampled residents. Resident #5 and Resident #6. Findings Include: Record review of the undated facility policy, Comprehensive Care Plans 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 a resident's medical, nursing, and mental and psychosocial needs . Resident #5 On 03/25/25 at 11:30 AM, an interview with Resident #5 revealed she did not get her shower on Saturday, 03/22/25, and she hadn't had a shower since last Thursday, 03/20/25. She revealed that she had missed several showers and stated, I've been averaging about one shower a week this month. Resident #5 revealed that her scheduled shower days were Tuesdays, Thursdays and Saturdays. She also revealed that she kept it in her calendar, and had it written down that she got a shower on 03/04/25 and did not get her next shower until 03/13/25 which was over a week later. Record review of Resident #5's Continuous Pressure Ulcer Monitoring Sheets which they used for keeping track of resident baths/showers revealed that she got her scheduled showers on 03/04/25, 03/13/25, 03/15/25, 03/18/25, and 03/20/25. Resident #5 did not receive her shower on 03/06/25, 03/08/25, 03/11/25, and 03/22/25. Record review of Resident #5's Care Plan initiated on 11/12/24 revealed that she had an Activity of Daily Living (ADL) self-care performance deficit related to weakness and had interventions in place that included she required assistance at times with bed mobility, transfers, dressing, toileting, hygiene, bathing and set up assist with eating. Record review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Need for Assistance with Personal Care. (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 - Few	Record review of Resident #5's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/11/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 13 which indicated that she had no cognitive deficits. Resident #6 On 03/25/25 at 2:55 PM, an interview with Resident #6 revealed that his scheduled shower days were Mondays, Wednesdays and Fridays. He revealed that he did not get a shower yesterday, 03/24/25 and he couldn't remember getting a shower at all last week. He revealed that he used to get his showers every Monday, Wednesday and Friday and now it was every once in a while. Record review of Resident #6's Continuous Pressure Ulcer Monitoring sheets which were used as bath and shower sheets revealed that he received showers on 03/03/25, 03/06/25, 03/11/25, 03/12/25, and 03/13/25 in the month of March. There were no other showers documented for Resident #6. Record review of Resident #6's Care Plan initiated on 09/28/22, revealed that he had an ADL self-care performance deficit related to Left Sided Hemiplegia, Impaired balance, Limited Mobility and history of Cerebrovascular Accident. His interventions included that he required extensive assistance to dependence with ADL's. Record review of Resident #6's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, and Need for Assistance with Personal Care. Record review of Resident #6's MDS with ARD of 02/11/25 under Section C revealed a BIMS Score of 15 which indicated that he had no cognitive deficits. On 03/25/25 at 3:35 PM, an interview with the Certified Nursing Assistant (CNA) Supervisor confirmed that according to the resident interviews and the review of the shower sheets, that Resident # 5 and Resident # 6 were missing showers for the month of March 2025. CNA Supervisor confirmed that Resident #5 and Resident #6 were both cognitively intact and since they reported not getting some of their showers and with the missing shower documentation sheets, they probably did not get their showers as scheduled. She also agreed that they needed a better system for tracking to ensure that baths, showers, and personal care were being completed and documented. An interview on 03/26/25 at 11:10 AM with Registered Nurse (RN) Supervisor, revealed that the purpose of the care plan was to know the complete plan of care and what was required to take care of their individualized needs of Resident #5 and Resident #6. She revealed that the care plan included what was allowed, what each resident preferred, safety measures, overall ADL care, and how they transferred. She revealed that the care plan was the complete picture of that resident. RN Supervisor confirmed that since Residents #5 and Resident #6 missed their scheduled showers, their ADL care plans were not followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 45598 Based on staff and resident interviews, record review and facility policy review the facility failed to provide care to maintain personal hygiene for two (2) of six (6) residents reviewed for Activities of Daily Living (ADL) care. Resident #5 and Resident #6. Findings Include: Record review of the undated facility policy, Activities of Daily Living (ADL's) revealed under Policy Explanation and Compliance Guidelines .3. The resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene Resident #5 An interview on 03/25/25 at 11:30 AM with Resident #5 revealed that the care at the facility wasn't perfect but was okay. Resident #5 revealed that she did not get her shower on Saturday, 03/22/25, and she hadn't had a shower since last Thursday, 03/20/25. She revealed that she had missed several showers and stated, I've been averaging about one shower a week this month. Resident #5 revealed that her scheduled shower days were Tuesdays, Thursdays and Saturdays and until the first of the year, she was getting her showers like clockwork. She also revealed that she kept it in her calendar, and had it written down that she got a shower on 03/04/25 and did not get her next shower until 03/13/25 which was over a week later. She also revealed that on the days of her missed showers, no one offered or mentioned a shower to her. Resident #5 revealed that she had night sweats and when she got to where she could smell herself, she went into the bathroom in her room and washed herself off the best she could. Resident #5 revealed that not getting her scheduled showers made her feel dirty and made her not want to be around anyone and stated, Because I didn't want anyone to smell me. Record review of Resident #5's Continuous Pressure Ulcer Monitoring Sheets which they used for keeping track of resident baths/showers revealed that she got her scheduled showers on 03/04/25, 03/13/25, 03/15/25, 03/18/25, and 03/20/25. Resident #5 did not receive her shower on 03/06/25, 03/08/25, 03/11/25, and 03/22/25. Record review of Resident #5's Admission Record revealed an admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Need for Assistance with Personal Care. Record review of Resident #5's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/11/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that she had no cognitive deficits. Resident #6 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/25/25 at 2:55 PM with Resident #6, revealed that his scheduled shower days were Mondays, Wednesdays and Fridays. He revealed that he did not get a shower yesterday, 03/24/25 and he couldn't remember getting a shower at all last week. He revealed that he used to get his showers every Monday, Wednesday and Friday and now it was every once in a while. Record review of Resident #6's Continuous Pressure Ulcer Monitoring sheets which were used as bath and shower sheets revealed that he received showers on 03/03/25, 03/06/25, 03/11/25, 03/12/25, and 03/13/25 in the month of March. There were no other showers documented as completed for Resident #6. Record review of Resident #6's Admission Record revealed an admitted [DATE] with diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, and Need for Assistance with Personal Care. Record review of Resident #6's MDS with ARD of 02/11/25 under Section C revealed a BIMS score of 15 which indicated that he had no cognitive deficits. An interview on 03/25/25 at 10:55 AM with Licensed Practical Nurse (LPN) #1, revealed that the Certified Nursing Assistants (CNAs) had to fill out a sheet on each resident and turn it in to the nurses to sign off on when a shower or bath was completed. She revealed that the shower sheets that they used were titled, Continuous Pressure Ulcer Monitoring. She also revealed that if a resident refused a bath or shower, the staff had to document refused and turn a sheet in for that day. LPN #1 revealed that once the bath sheets were turned in and the skin assessment part was looked at, the nurse signed off on it and the shower sheets were turned in to Certified Nursing Assistant (CNA) Supervisor to be filed. An interview on 03/25/25 at 3:35 PM with the Certified Nursing Assistant (CNA) Supervisor, revealed that the shower sheets they used were the Continuous Monitoring Pressure Ulcer Monitoring sheets. She revealed that the CNAs filled them out on each resident when they gave showers or baths, and they documented any new skin breakdown. CNA Supervisor revealed that the CNAs turned the sheets in to the nurses and the nurses had to sign off that the showers were completed and then turn them in to her for filing. She revealed that she had not received any complaints about residents not getting their showers. CNA Supervisor confirmed that there were missing shower sheets on Resident #5 and Resident #6 for the month of March 2025 and the lack of documentation would indicate that they didn't get showers on those days. CNA Supervisor confirmed that Resident #5 and Resident #6 were both cognitively intact and since they reported not getting some of their showers and with the missing shower documentation sheets, they probably did not get their showers as scheduled. She also agreed that they needed a better system for tracking to ensure that baths, showers, and personal care were being completed and documented. An interview on 03/26/25 at 9:10 AM with Administrator (ADM), revealed that he was not aware of any residents missing their baths or showers and said it could be from the lack of stabilization in staffing and stated, We can get that back under control and get this issue fixed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/26/25 at 11:10 AM with Registered Nurse (RN) Supervisor, revealed that the CNAs had to fill out a shower sheet on each resident when they complete it and turn the sheet in to the nurse and the nurse had to sign off on it. She revealed that the sheets had to be filled out and signed by the CNA and the nurse even if a resident refused the service. RN Supervisor revealed that she was not aware that showers were being missed until now, and it was very concerning to her. She revealed that she would find out where the breakdown was and would be working on putting something in place to rectify the situation, so it didn't happen again. RN Supervisor revealed that going forward, she would make sure that she as well as the nurses collected the shower sheets on all residents and make sure everyone received their baths or showers as scheduled.