

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255312		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER UNION CO HEALTH AND REHAB CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 BRATTON ROAD , NEW ALBANY, Mississippi, 38652			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey at the facility from 08/03/26 through 08/06/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies F550, F641, F656, F677, F761, F812, and F880. The census at the time of the survey was 52 and the facility was licensed for 60 beds.		F0000				
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.		F0550				

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 reverse for further 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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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to ensure a resident's right to be treated with respect for one (1) of 52 residents reviewed. Anonymous Resident #1 Findings Include: Review of facility policy, "Resident Rights", revision date October 2025 revealed "...Employees shall treat all residents with kindness, respect, and dignity..." During an interview with Anonymous Resident #1 on 08/03/2026 at 11:30 AM, the resident stated that Certified Nursing Assistant (CNA) #5 entered her room the previous week while her roommate was attempting to get out of bed without assistance. Anonymous Resident #1 stated she had yelled out for help because she was afraid her roommate would fall and she did not have time to activate the call light. The resident stated that CNA #5 entered the room and yelled, "Stop yelling, crazy lady!" Anonymous Resident #1 stated CNA #5 frequently talks roughly to her and yells at her. The resident stated she had not reported the behavior because she feared retaliation. On 08/05/2026 at 8:35 AM during an interview with CNA #4, she revealed she had personally witnessed CNA #5 speaking to residents in a hateful and disrespectful manner, specifically Anonymous Resident #1. CNA #4 stated management was aware residents had previously complained regarding CNA #5 and the manner in which she communications with residents. During a telephone interview on 08/05/2026 at 11:00 AM with CNA #5, she revealed she was aware residents had complained to administration regarding the way she communicated with them. CNA #5 stated she talks loudly but did not believe			F0550			

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F0550 SS = D	Continued from page 2 she was being rude. CNA #5 acknowledged administration had counseled her in April and again in May of this year regarding resident complaints about her tone of voice. CNA #5 stated she could understand how residents might perceive her communication as rude and stated she would try to improve the loudness of her voice and her tone. Record review of the Resident Grievance/Complaint Form dated 5/3/26 revealed "I turned on my light and CNA #5 knocked very hard and loud on my door. I asked her not to knock so loud and she was rude and said 'That's how I knock. What do you want?' I asked for pain pill and she did not tell my nurse...Recommendations/corrective actions taken: none. Unsubstantiated...CNA #5 agreed to be more aware of how hard she knocks..." Record review of the Resident Grievance/Complaint Investigation Report Form dated 4/15/2026 revealed CNA #5 received counseling regarding her conduct while working with residents. The attachment revealed the resident stated, "at times (CNA #5) is nice to her but most of the time she 'gets smart'. Resident said when she asked (CNA #5's) name, (CNA #5) asked her 'why are you going to report me?'. Then later she stuck her head inside her door and asked if the reason (Resident) needed her name was because she was going to be reported...(Resident)...wants to be spoken to respectfully..." Documentation indicated residents perceived her tone of voice and communication as rude and disrespectful. Record review of a Teachable Moment counseling form dated 4/15/2026 revealed CNA #5 was instructed to be mindful of her tone of voice and how her communication may be perceived by residents. Record review of Record of In-service Training by the Medicaid Fraud Control Unit of the Attorney General's office revealed CNA #5 completed an Abuse, Neglect and Exploitation in-service on 4/09/2026. Record review revealed CNA #5 also completed Resident Rights education on 7/01/2026. During an interview on 08/04/2026 at 4:00 PM, the Director of Nursing (DON) stated she had not received any recent complaints regarding CNA #5's communication with residents. During an interview on 08/05/2026 at 3:00 PM, the Administrator stated CNA #5 had previously been counseled regarding resident complaints related to the manner in which she spoke to residents. The			F0550			

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F0550 SS = D	Continued from page 3 Administrator stated CNA #5 "She does talk loud," and stated he was unaware of any recent complaints.	F0550					
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected medications administered during the applicable seven-day look-back periods for two (2) of 20 residents reviewed for resident assessment accuracy. Residents #4 and Resident #46	F0641					

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F0641 SS = D	Continued from page 4 Findings include: Review of the facility policy titled "Comprehensive Assessments," dated October 2023, revealed: "...The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by Centers for Medicare and Medicaid Services (CMS)..." Resident #4 Record review of Resident #4's most recent completed MDS assessment, with an Assessment Reference Date (ARD) of 06/11/2026, revealed Section N0350A, Insulin Injections—Record the number of days that insulin injections were received during the last seven days or since admission/entry or reentry if less than seven days, was coded "7," indicating the resident received insulin injections on seven days during the look-back period. Record review of Resident #4's June 2026 Medication Administration Record (MAR) revealed no physician's order for insulin and no documented administration of insulin during the seven-day look-back period for the MDS assessment. Record review of the Admission Record indicated Resident #4 was admitted to the facility on 6/2/2026 with medical diagnoses that included Anemia, Hypokalemia, and Hyperglycemia. Record review of the MDS, with an ARD of 7/27/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #4 was cognitively intact. Resident #46 Record review of Resident #46's MDS assessment, with an ARD of 06/29/2026, revealed Section N0415F1 Antibiotic, was coded to indicate the resident was taking an antibiotic during the seven-day look-back period. Record review of Resident #46's June 2026 MAR revealed no documented administration of an antibiotic during the seven-day look-back period for the MDS assessment. Record review of the Admission Record indicated Resident #46 was admitted to the facility on 7/30/2025 with medical diagnoses that included Hypertensive Heart Disease without Heart Failure.	F0641					

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F0641 SS = D	Continued from page 5 Record review of the MDS, with an ARD of 6/29/2026, revealed under Section C a BIMS score of 5, indicating Resident #46 had severe cognitive impairment. During an interview and record review on 08/06/2026 at 4:08 PM, the Registered Nurse (RN) Consultant reviewed and confirmed the MDS findings for Residents #4 and Resident #46. She confirmed Resident #4's MDS assessment inaccurately reflected seven days of insulin injections and Resident #46's MDS assessment inaccurately reflected antibiotic use during the applicable seven-day look-back period. She stated that the accuracy of MDS assessments was very important because the assessments painted a picture of how residents should be cared for and assisted the facility in developing residents' care plans.	F0641					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-	F0656					

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F0656 SS = D	Continued from page 6 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. \$483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement Activities of Daily Living (ADL) care plans for four (4) of 52 residents reviewed. Residents #2, Resident #26, Resident #38, and Resident #54 Findings include: Review of the facility's policy titled, "Care Plan, Comprehensive Person-Centered" with no revision date, revealed under "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..." Resident #2 Record review of Resident #2's ADL care plan revealed, "...Interventions...Check nail length and trim and clean on bath day and as necessary..." Record review of Resident #2's most recently completed Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/01/26, revealed Section GG0130I, Personal Hygiene, was coded "05—Set-up or clean-up assistance," indicating a helper provided assistance by setting up or cleaning up before or after the activity, while the resident completed the activity..."	F0656					

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F0656 SS = D	Continued from page 7 On 08/03/2026 at 10:40 AM, Resident #2 was observed with fingernails approximately one-half inch in length and a dark-brown substance underneath the nails. On 08/05/2026 at 11:26 AM, an observation revealed Resident #2's fingernails remained approximately one-half inch in length with a dark-brown substance underneath. During an observation and interview on 08/05/2026 at 12:16 PM, Certified Nursing Assistant (CNA) #2 observed Resident #2's fingernails and confirmed they were dirty and needed to be trimmed. CNA #2 stated, "Nail care should be done daily." She further stated that the wound-care nurses were responsible for trimming residents' fingernails. During an interview on 08/05/2026 at 12:25 PM, the Director of Nursing (DON) stated CNAs could file the fingernails of residents who did not have diabetes; however, she preferred that nurses' trim residents' fingernails. She stated she expected CNAs to ensure residents' fingernails were cleaned daily. An interview on 08/06/2026 at 12:50 PM with MDS Coordinator revealed that the comprehensive care plan was intended to communicate each resident's individualized needs and preferences to staff, including bathing schedules and required assistance. Record review of the Admission Record revealed Resident #2 was admitted to the facility on 11/29/2025 with medical diagnoses that included Hypertensive Heart Disease without Heart Failure. Record review of the MDS, with an ARD of 7/1/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 3, indicating Resident #2 had severe cognitive impairment. Resident #26 Record review of the Care Plan Report for Resident #26 revealed: "The resident has an ADL self-care performance deficit related to (r/t) confusion and right sided hemiplegia due to stroke... Interventions: ...Shave on shower days and prn (as needed). The resident is totally dependent on one staff to provide bath/shower..." During an observation and interview on 08/03/2026			F0656			

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F0656 SS = D	Continued from page 8 at 11:10 AM, and again on 8/04/2026 at 11:00 AM, Resident #26, was observed lying in bed with facial hair approximately 1/4 inch in length. Resident #26 stated he had not been shaved lately, and he would like a shave. He couldn't remember his shower days but stated they should shave me on shower days. Resident #26 was sitting in the hall near the shower room on 8/05/2026 at 10:30 AM, he had not been shaved. He stated he wanted a shave. Record review of Resident #26's Shower Sheet revealed he is showered on Tuesdays, Thursdays, and Saturdays. During an interview on 8/05/2026 at 10:40 AM with Director of Nursing (DON) revealed she was unaware Resident #26 had not been shaved this week. She stated the wound care coordinator shaves Resident #26, and he has been covering for another nurse and didn't have time. An interview on 08/06/2026 at 12:50 PM with MDS Coordinator revealed that the comprehensive care plan was intended to communicate each resident's individualized needs and preferences to staff, including bathing schedules and required assistance. Record review of Resident #26's MDS with ARD of 6/02/2026 under Section GG revealed he required partial/moderate assistance with his personal hygiene including shaving. Record review of Resident #26's "Admission Record" revealed he was admitted to the facility on 3/04/2024 with a diagnosis that included atherosclerotic heart disease. Record review of Resident #26's MDS with an ARD of 6/02/2026 under Section C revealed a BIMS score of 05 which indicated he was severely cognitively impaired. Resident #38 An observation and interview on 08/03/2026 at 12:28 PM with Resident #38 revealed him resting in bed with visibly greasy, unwashed hair. The resident stated he had not received a shower in four days and commented that if he had to go home to get his	F0656					

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F0656 SS = D	Continued from page 9 showers, he would. He revealed that he had a fractured right elbow and required help with his showers. An interview on 08/05/2026 at 11:18 AM with Lead CNA revealed that Resident #38 was scheduled for showers every Tuesday, Thursday, and Saturday because he preferred not to shower before his early morning dialysis appointments. She stated she personally provided his shower on Thursday of the previous week and that the resident informed her on Monday, 08/03/2026, that he had not received another shower since then. An interview on 08/06/2026 at 9:15 AM with Director of Nursing (DON) revealed that she was unaware that Resident #38 had missed his scheduled showers over the weekend. She acknowledged that residents not receiving scheduled showers was not acceptable. An interview on 08/06/2026 at 12:50 PM with MDS Coordinator revealed that the comprehensive care plan was intended to communicate each resident's individualized needs and preferences to staff, including bathing schedules and required assistance. She further confirmed that by failing to provide Resident #38 with his showers on his scheduled shower days, the facility failed to follow the resident's care plan. Record review of Resident #38's "Care Plan Report" revealed that he has an ADL self-care performance deficit related to fractures of right olecranon requiring surgical repair and inferior pubic ramus. Interventions included, "The resident requires partial assist by one staff with bathing/showering." Record review of Resident #38's "Admission Record" revealed that he was admitted to the facility on 07/10/26 with diagnoses that included End Stage Renal Disease and Hypertensive Heart Disease with Heart Failure. Record review of Resident #38's MDS with an ARD of 07/17/26 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Resident #54 Review of the Care Plan Report for Resident #54			F0656			

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F0656 SS = D	Continued from page 10 revealed: "The resident has an ADL self-care performance deficit r/t cognitive deficit...Interventions: ...Shave on shower days and prn..." During an observation and interview on 8/03/2026 at 10:50 AM, and again on 8/04/2026 at 11:05 AM, Resident #54 was observed in his wheelchair outside of his room, he was observed to have approximately one-fourth (1/4) inch in length facial hair. Resident #54 stated that he had not been shaved lately. He stated it wasn't his shower day on Monday, but he would have a shave and shower tomorrow hopefully. Resident #54 was sitting in his wheelchair near his room on 8/05/2026 at 8:00 AM, he had not been shaved. He stated he would like to be shaved. Record review of Resident #54's Shower Sheet revealed he is showered on Tuesdays, Thursdays, and Saturdays. During an interview on 8/05/2026 at 10:41 AM, with DON revealed that she was unaware Resident #54 had not been shaved this week. During an interview with MDS Coordinator on 8/05/2026 at 4:30 PM, she stated, "If the resident did not have his shave on his shower day and he wanted his shave, the care plan was not implemented. She stated the purpose of a care plan is for the resident to receive the individualized care they need." Record review of Resident #54' s "Admission Record" revealed that he was admitted to the facility on 12/20/2023 with a diagnosis that included Unspecified Dementia. Record review of Resident #54's Admission MDS with ARD of 6/16/2026 under Section C revealed a BIMS Score of 12 which indicated that he was moderately cognitively impaired.			F0656			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			F0677			

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F0677 SS = D	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for four (4) of 52 residents reviewed for ADL care. Resident # 2, Resident #26, Resident #38, and Resident #54. Findings include: Review of the facility policy "Activities of Daily Living (ADLs)" with revision date of April 2025 revealed, "...Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene..." Resident #2 An observation on 08/03/2026 at 10:40 AM, revealed Resident #2 with fingernails approximately one-half inch in length and a dark-brown substance underneath the nails. During an observation on 08/05/2026 at 11:26 AM, Resident #2's fingernails remained approximately one-half inch in length with a dark-brown substance underneath. An observation and interview on 08/05/2026 at 12:16 PM, Certified Nursing Assistant (CNA) #2 observed Resident #2's fingernails and confirmed they were dirty and needed to be trimmed. CNA #2 stated, "Nail care should be done daily." She further stated that the wound-care nurses were responsible for trimming residents' fingernails. During an interview on 08/05/2026 at 12:18 PM, the Wound Care Coordinator stated that only a Registered Nurse (RN) could trim the fingernails of residents with diabetes. He stated CNAs could trim the fingernails of residents who did not have diabetes, but nail trimming usually became the nurses' responsibility. An interview with the Director of Nursing (DON) on 08/05/2026 at 12:25 PM, she revealed CNAs could file the fingernails of residents who did not have diabetes; however, she preferred that nurses' trim residents' fingernails. She stated she expected CNAs to ensure residents' fingernails were cleaned daily. Record review of the Admission Record revealed			F0677			

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F0677 SS = D	Continued from page 12 Resident #2 was admitted to the facility on 11/29/2025 with medical diagnoses that included Hypertensive Heart Disease without Heart Failure. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/1/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 3, indicating Resident #2 had severe cognitive impairment. Resident #26 An observation and interview on 08/03/2026 at 11:10 AM, and again on 8/04/2026 at 11:00 AM with Resident #26, revealed that the resident was lying in bed with facial hair approximately 1/4 inch in length. Resident #26 stated he had not been shaved lately, and he would like a shave. He couldn't remember his shower days but stated that they should shave him on his shower days. On 8/05/2026 at 10:30 AM, an observation of Resident #26 revealed he was sitting in the hall near the shower room and he had not been shaved, but confirmed he wanted a shave. Record review of Resident #26's Shower Sheet revealed he is showered on Tuesdays, Thursdays, and Saturdays. An interview on 8/05/2026 at 10:40 AM with DON revealed she was unaware Resident #26 had not been shaved this week. She stated the wound care coordinator shaves Resident #26, and he has been covering for another nurse and didn't have time this week. Record review of Resident #26's "Admission Record" revealed he was admitted to the facility on 3/04/2024 with diagnoses that included heart disease. Record review of Resident #26's MDS with ARD of 6/02/2026 under Section C revealed a BIMS score of 05 which indicated he was severely cognitively impaired. Resident #38 On 08/03/2026 at 12:28 PM, an observation and	F0677					

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F0677 SS = D	Continued from page 13 interview with Resident #38 revealed the resident resting in bed with visibly unwashed, greasy hair. Resident #38 stated he had not received a shower in four days and commented that if he had to go home to get his showers, he would. He had an intact half-cast on his right arm and stated he required help with his showers. On 08/04/2026 at 3:25 PM, interview with Resident #38's wife revealed the only concern she had with the facility was the lack of scheduled showers. She stated she visited the resident daily and learned on Monday, 08/03/26, that he had not received a shower since Thursday, 07/30/26, resulting in four days without bathing. She reported requesting assistance from staff on both Saturday and Sunday to help the resident receive a shower, but staff advised they would check on it and never returned. Resident #38's wife stated that prior to admission, the resident showered and washed his hair every day and it was important to him to be clean. She further stated they had visitors over the weekend, and she wanted him to be clean and presentable. She confirmed the resident finally received a shower on Monday afternoon after returning from dialysis, which was not his scheduled shower day. She also reported that after the resident informed nursing staff that surveyors had asked about his missed showers, staff immediately assisted him with a shower. She expressed that it was upsetting to know he had gone without appropriate hygiene care and stated she simply wanted him to be properly cared for. On 08/05/2026 at 11:18 AM an interview with the Lead CNA revealed that Resident #38 was scheduled for showers every Tuesday, Thursday, and Saturday because he preferred not to shower before his early morning dialysis appointments. She stated she personally provided his shower on Thursday of the previous week and that the resident informed her on Monday, 08/03/2026, that he had not received another shower since then. Lead CNA stated that Resident #38 told her he felt dirty going to dialysis without bathing. She revealed that she apologized and assured him she would personally make sure he received his scheduled showers going forward. On 08/06/2026 at 9:15 AM an interview with the DON revealed that she was unaware Resident #38 had missed his scheduled showers over the weekend. She acknowledged that residents not receiving scheduled showers was unacceptable. She also agreed that failing to provide scheduled bathing			F0677			

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F0677 SS = D	Continued from page 14 could negatively impact a resident's dignity, self-esteem, hygiene, and cause embarrassment due to feeling or appearing unclear. Record review of Resident #38's "Admission Record" revealed that he was admitted to the facility on 07/10/26 with diagnoses that included End Stage Renal Disease and Hypertensive Heart Disease with Heart Failure. Record review of Resident #38's Admission MDS with ARD of 07/17/26 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Resident #54 Aan observation and interview on 8/03/2026 at 10:50 AM, and again on 8/04/2026 at 11:05 AM with Resident #54 it revealed the resident in his wheelchair outside of his room, he was observed to have approximately 1/4 inch in length facial hair. Resident #54 stated that he had not been shaved lately and his shower day was on Monday. An observation and interview with Resident #54 on 8/05/2026 at 8:00 AM revealed he had not been shaved and stated he would like to be shaved. An interview on 8/05/2026 at 10:41 AM, with the DON revealed that she was unaware Resident #54 had not been shaved this week. She stated the Wound Care Coordinator shaves Resident #54 and he has been covering for another nurse and didn't have time. During an interview on 8/06/2026 at 8:10 AM with the Wound Care Coordinator, he stated he was really busy on 8/05/2026 with extra work and forgot to ask Resident #54 if he wanted to be shaved. Record review of Resident #54' s "Admission Record" revealed that he was admitted to the facility on 12/20/2023 with a diagnosis that included Unspecified Dementia. Record review of Resident #54's Admission MDS with ARD of 6/16/2026 under Section C revealed a BIMS Score of 12 which indicated that he had moderate cognitive impairment.			F0677			

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F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and facility policy review, the facility failed to store medications safely and securely for two (2) of four (4) days of survey. Findings include: Review of facility policy titled "Storage of Medications" revised April 2007, revealed, "...The facility shall store all drugs and biologicals in a safe, secure, and orderly manner..." Resident #46 On 8/3/2026 at 10:50 AM an observation revealed an unlabeled medication cup containing a residual amount of an unidentified pink, cream-like substance unsecured on Resident #46's bedside nightstand. Resident #46 occupied a shared room. During a follow-up observation and interview on 8/3/2026 at 10:52 AM, the Minimum Data Set (MDS) Coordinator observed the substance and stated that			F0761			

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F0761 SS = D	Continued from page 16 it "looks like Calmoseptine," and confirmed that a medicated cream should not have been left at the bedside. Resident #49 An observation and interview on 8/3/2026 at 10:29 AM, it was observed an unlabeled medication cup approximately one-third full of an unidentified white, cream-like substance left unattended at Resident #49's bedside. Resident #49 occupied a shared room and stated, "The nurse brought it in. She is coming back to do my treatment." On 8/3/2026 at 10:36 AM, the medication cup remained unattended at Resident #49's bedside. During a concurrent observation and interview, the Wound Care Coordinator confirmed that the medication cup contained a white, cream-like substance and should not have been left at the bedside. He stated, "Another resident could get it and use it inappropriately or even possibly eat it if they weren't of sound mind." During an interview on 8/4/2026 at 4:55 PM, the DON confirmed that medication cups containing medicated creams should never be left unattended at a resident's bedside. She stated that leaving medicated creams unsecured at the bedside presented a safety concern because they could be accessed by other residents. During an observation in the hallway near the nurses' station on 8/5/2026 at 12:16 PM, the medication cart assigned to the 400 Hall was observed unlocked and unattended. The cart's push-lock mechanism was extended in the unlocked position, and the medication-containing drawers, which contained prescription medications was accessible. The medication cart remained unlocked and unattended for approximately two minutes while the assigned nurse was inside a resident's room and was not in a position to maintain immediate control of the cart. During this time, residents, visitors, and staff passed through the hallway near the cart. During an interview on 8/5/2026 at 12:18 PM, the medication-cart nurse, Licensed Practical Nurse (LPN) #2, stated, "I just grabbed something really quick and walked away for a minute." LPN #2 confirmed that the medication cart should never be left unlocked and stated, "Anyone could get something out of the cart and accidentally take the wrong medication."	F0761					

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F0761 SS = D	Continued from page 17 During an interview on 8/5/2026 at 12:30 PM, the DON confirmed that medication carts should be locked whenever left unattended. She stated that leaving a medication cart unlocked created a risk because anyone could access and remove medications from the cart.	F0761					
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure that time/temperature control for safety (TCS) foods were maintained under appropriate temperature control and discarded when required, and failed to consistently monitor and document food storage and holding temperatures for one (1) of four (4) days of survey. Findings Include: Review of the facility policy titled," Monitoring Temperature of Cooked Foods" with a revision date of 10/17, revealed, "...3. Cooking and holding temperatures should be recorded at each meal..." Review of facility policy titled "Resident Nutrition	F0812					

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F0812 SS = D	Continued from page 18 Services" undated revealed, "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident...2...Reasonable efforts will be made to accommodate resident choices and preferences...4.b...Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than two (2) hours will be discarded..." On 8/03/2026 at 10:21 AM, during a kitchen observation with the Certified Dietary Manager (CDM), review of the Food Holding Temperature Log and Refrigerator/Freezer Temperature Log revealed incomplete documentation on 8/01/2026 and 8/02/26. The Refrigerator/Freezer Temperature Log revealed no recorded AM refrigerator/freezer temperatures for 8/01/26 and 8/02/2026, and the Food Holding Temperature Log revealed no recorded temperatures on 8/01/2026 and 8/02/2026. During an interview on 8/03/2026 at 10:22 AM with the CDM, she stated, "I have discussed with staff the importance of checking temperatures and keeping a temperature log of food storage and cooked foods to help ensure food safety." During an interview with the Administrator on 8/06/26 at 10:00 AM, he stated it was the facility's expectation that refrigerator and freezer temperatures are monitored and recorded twice daily, and that steam table temperatures are monitored and documented for each meal. On 08/03/2026 at 10:45 AM, Resident #24 was observed asleep in bed. An untouched breakfast tray containing a cooked sausage and biscuit remained on her bedside table. Record review of the tray delivery schedule confirmed Resident #24's breakfast tray was delivered at approximately 7:30 AM; therefore, the tray remained at bedside for approximately three hours and 15 minutes. The tray was not observed to be under hot or cold temperature control and contained no visible marking identifying its delivery or discard time. During an observation and interview on 08/03/2026 at 10:49 AM the Infection Control Nurse identified the tray as Resident #24's breakfast tray and confirmed that it contained an uneaten cooked sausage and biscuit. The nurse stated breakfast trays were usually collected by 9:00 a.m. When asked about the length of time the food should have			F0812			

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F0812 SS = D	Continued from page 19 remained at bedside, she stated, "Not this long." The nurse further stated Resident #24 frequently slept late and that staff often left her breakfast tray at bedside for her to eat after awakening because "she's very particular." During an interview on 08/04/2026 at 4:54 PM, the Director of Nursing confirmed that Resident #24 regularly slept late and that leaving her breakfast tray at bedside until she awakened was the usual practice. The DON did not identify a system for maintaining breakfast food at a safe temperature, tracking the length of time the food remained without temperature control, or discarding and replacing TCS food. After discussing safe food-handling requirements, the DON stated that leaving foods such as cooked sausage at room temperature for extended periods could result in foodborne illness. Record review of the Admission Record indicated Resident #24 was admitted to the facility on 6/27/2017 with medical diagnoses that included Hypertensive Heart Disease without Heart Failure. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/8/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #24 had moderate cognitive impairment.	F0812			
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based	F0880			

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F0880 SS = D	Continued from page 20 upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880					

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F0880 SS = D	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews and facility policy review, the facility failed to implement infection-prevention and control practices for three (3) of five (5) resident care practices observed. Residents #4, Resident #6, and Resident#55 Findings Include: Review of the facility policy "Enhanced Barrier Precautions" with revision date of December 2024, revealed "Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents...2. Enhanced barrier precautions apply when... b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained..." Review of facility policy titled "Infection Control Guidelines" undated revealed, "...4. Enhanced Barrier Precautions (EBP) will be used for residents with chronic wounds or indwelling medical devices during high-contrast resident care activities regardless of the resident's multidrug-resistant organism status..." Review of facility policy titled "Cleaning and Disinfection of Environmental Surfaces" revised June 2009, revealed, "Environmental surfaces will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard..." Review of facility policy titled "Handwash Hygiene" reviewed April 2018, revealed, "...7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water...for the following situations...e. Before and after handling an invasive device (e.g., urinary catheters...h. Before moving from a contaminated body site to a clean body site during resident care..." Review of facility policy titled "Standard Precautions" reviewed December 2007, revealed, "...Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may			F0880			

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NAME OF PROVIDER OR SUPPLIER UNION CO HEALTH AND REHAB CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 BRATTON ROAD , NEW ALBANY, Mississippi, 38652			
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F0880 SS = D	Continued from page 22 contain transmissible infectious agents...Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another...Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces...and wash hands immediately to avoid transfer of microorganisms to other residents or environments...Remove gown and perform hand hygiene before leaving the resident's room..." Review of facility policy titled "Suctioning Upper Airway Oral" revised October 2010, revealed, "...Empty and rinse collection container if necessary or as indicated by facility protocol..." Review of facility policy titled, "Suprapubic Cath Care" revised August 2019, revealed, "The purpose of this procedure is to prevent skin irritation around the stoma site and prevent infection of the resident's urinary tract...Discard disposable items into designated containers. Remove gloves and discard in designated container. Wash and dry your hands thoroughly..." Review of the facility policy titled "Catheter Care Urinary" revised 9/2014, revealed the purpose of this procedure was "to prevent catheter-associated urinary tract infections." The policy directed staff to ensure catheter tubing and drainage bag are kept off the floor. Resident #4 Suction Canister On 08/03/2026 at 10:17 AM, a suction canister connected to Resident #4's suction machine was observed at the bedside. The canister was approximately 85% full of cloudy secretions. During the interview, Resident #4 stated the suction machine had not been used in approximately one month and that the secretions had remained in the canister throughout that time and that nobody had emptied it. During a follow-up observation and interview on 08/03/2026 at 10:24 AM, the Quality Assurance (QA) Nurse observed the suction canister and confirmed that it was full of retained secretions. She stated she could not confirm how long the secretions had remained in the canister. The QA Nurse stated she was uncertain of the facility's required replacement or disposal frequency but believed the canister should be emptied at least once per shift. During an interview on 08/04/2026 at 4:54 PM, the Director of Nursing (DON) confirmed that Resident	F0880					

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F0880 SS = D	Continued from page 23 #4's suction canister should not have been left at the bedside while full of retained respiratory secretions. They acknowledged that allowing respiratory secretions to remain in the canister at the bedside constituted an infection-control concern and stated staff should have emptied or replaced the canister. During an interview on 08/06/2026 at 1:18 PM, the Nurse Consultant stated the facility did not have a facility protocol specifying how frequently suction canisters should be emptied, cleaned, or replaced. She stated her expectation was for staff to empty and rinse the canister at the end of each shift and replace it weekly. Resident #4 Catheter Care During an observation and interview on 8/3/26 at 10:17 AM with Resident #4, he stated he had an indwelling urinary catheter that had been inserted during his recent hospitalization. The urinary drainage bag was attached to his wheelchair and the bottom of the drainage bag extended below the privacy cover and was observed in direct contact with the floor. During an observation and interview on 8/3/2026 at 10:23 AM, the QA Nurse confirmed that Resident #4's urinary drainage bag was touching the floor. The QA Nurse immediately repositioned the drainage bag off the floor and stated that a urinary drainage bag should never touch the floor because doing so creates a risk for infection. During an observation on 08/05/2026 at 11:39 AM, Certified Nursing Assistant (CNA) #1 and CNA #2 provided fecal incontinence and suprapubic catheter care to Resident #4. It was observed that there was stool in his brief, and after removing the stool and providing incontinent care, both CNAs proceeded directly to suprapubic catheter care without removing their contaminated gloves, performing hand hygiene, and applying clean gloves. While continuing to wear the same gloves used during fecal incontinence and suprapubic catheter care, CNA #2 opened and searched Resident #4's dresser drawers for a care item. When she was unable to locate the item, CNA #2 removed her gloves but did not perform hand hygiene. She then exited the resident's room while continuing to wear the gown used during the resident's fecal incontinence and catheter care. CNA #1 continued wearing the same gloves used during fecal incontinence and catheter care and touched the bathroom doorknob, dresser drawer, and soap bottle. Observation then revealed a			F0880			

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F0880 SS = D	Continued from page 24 transfer of Resident #4 back into his wheelchair, CNA #1 allowed the suprapubic catheter drainage bag to rest directly on the floor multiple times during the transfer. During an interview on 08/05/2026 at 12:24 PM, the DON stated CNA #1 and CNA #2 were relatively new facility employees but had worked as CNAs for many years. She stated both CNAs received training upon hire and completed competency evaluations that included catheter care and infection control practices. The DON stated she expected staff to follow infection control practices while providing resident care and acknowledged that failure to follow those practices could result in a spread of infections, particularly for a resident with a urinary catheter. Record review of the facility documents titled "CNA Skills and Evaluation—On Hire and Annually" revealed CNA #1 was evaluated and documented as competent in catheter care on 03/05/2026, and CNA #2 was evaluated and documented as competent in catheter care on 05/04/2026. Record review of the Admission Record revealed Resident #4 was admitted to the facility on 6/2/2026 with medical diagnoses that included Anemia, Hypokalemia, and Hyperglycemia. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/27/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #4 was cognitively intact. Resident #6 On 08/06/2026 at 9:25 AM, an observation revealed Licensed Practical Nurse (LPN) #2 administering medications to Resident #6 through her percutaneous endoscopic gastrostomy (PEG) tube without utilizing EBP. LPN #2 did not wear the required isolation gown while providing care involving the resident's indwelling device. Immediately following the medication administration, LPN #2 confirmed she had not worn a gown during the procedure and stated, "I got distracted and forgot." She stated disposable gowns were available on hallway supply carts and that she normally obtained one before entering the resident's room. She acknowledged that facility protocol required the use of both a gown and gloves when providing care to residents requiring Enhanced Barrier Precautions. She further stated that failure to utilize the required	F0880					

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F0880 SS = D	Continued from page 25 personal protective equipment could cause the spread of germs and was intended to protect residents from contamination and possible infection. On 08/06/2026 at 10:05 AM, interview with the Infection Control Nurse revealed the purpose of Enhanced Barrier Precautions was to prevent the transmission of germs between staff and residents. She stated residents requiring EBP were identified by a red indicator on the outside of their room door. She confirmed Resident #6 had a PEG tube, which required staff to wear both gloves and a gown during care involving the device. She further explained that Enhanced Barrier Precautions are required for residents with open wounds, indwelling catheters, PEG tubes, and other indwelling medical devices. The Infection Control Nurse confirmed LPN #2 should have worn a gown while administering medications through the resident's PEG tube and acknowledged that failure to do so increased the risk for the spread of organisms, contamination, and potential infection. Record review of Resident #6's "Admission Record" revealed that she admitted to the facility on 12/01/25 with diagnoses that included Encounter for Attention to Gastrostomy and Dysphagia. Record review of Resident #6's Quarterly MDS with ARD of 06/22/26 under Section K documented "Yes" that she had a feeding tube. Resident #55 On 08/03/2026 at 11:22 AM, a pungent odor was noted in Resident #55's room. An observation and an interview at that same time with Resident #55 revealed an uncovered basin containing an emesis-like substance was observed on the floor beside the resident's bed. Resident #55 stated the basin had remained on the floor since the previous day. She stated, "I vomited several times yesterday. I don't know why that is still down there." During a follow-up observation and interview on 08/03/2026 at 11:25 AM, the Infection Control (IC) Nurse observed the uncovered basin on the floor and confirmed that it contained a substance that appeared to be emesis. She immediately removed and cleaned the basin. She further stated a nurse should have entered to administer morning medications and CNAs should have entered to provide care; therefore, a staff member should have			F0880			

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F0880 SS = D	Continued from page 26 identified and removed the basin. During an interview on 08/04/2026 at 4:56 PM, the DON stated that leaving an uncovered container of body fluids in the resident's room constituted an infection-control concern and that multiple staff would have been in the room the last 24 hours and should have removed it from the room. Record review of the Admission Record revealed Resident #55 was admitted to the facility on 7/13/2026 with medical diagnoses that included Unspecified Atrial Fibrillation. Record review of the MDS, with an ARD of 7/20/2026, revealed under Section C a BIMS score of 13, indicating Resident #55 was cognitively intact.			F0880			