

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER REST HAVEN HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 103 CUNNINGHAM DRIVE , RIPLEY, Mississippi, 38663			
(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	
M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey and Complaint Investigation (CI) MS#3109952 at the facility from 08/17/26 to 08/20/26. CI MS#3109952 was investigated related to sufficient staffing with no deficiency cited. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M610, M640, M655, M935 and M1570. The facility had a census of 47 and was licensed for 60 beds.		M0000				
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level IIBased on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care related to fingernail hygiene for one (1) of 47 residents reviewed for ADL care. Resident #2 Findings Include: Review of the facility policy titled "Resident Hygiene", Bath and Shower Standard" with a revision date of June 2022 revealed under "Standard It is the practice of the facility to assist residents		M0610				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0610	Continued from page 1 with bathing/showering to maintain proper hygiene and help prevent skin infections. Bathing includes washing the entire body and residents' fingernails and toenails would be trimmed when needed..." During an observation and interview on 8/17/26 at 10:55 AM revealed Resident #2's fingernails were approximately one-half (1/2) inch in length with a brown substance underneath the nails. Resident #2 stated staff shaved him and cut his nails, and he would like his fingernails trimmed because they were "really long." During an observation on 8/18/2026 at 8:56 AM, Resident #2's fingernails remained approximately one-half (1/2) inch in length with a brown substance underneath the nails. On 8/18/2026 at 9:00 AM, Licensed Practical Nurse (LPN) #2 stated Resident #2 received nail care on his shower days. During an interview on 8/20/2026 at 9:05 AM, Certified Nursing Assistant (CNA) #5 stated she helps with showers and that Resident #2 received nail care during his showers on Monday, Wednesday, and Friday. CNA #5 stated she washed the resident's nails and trimmed them when the resident told her he wanted them trimmed, they do not have a specific day of the week or time of the month to check if they need their nails trimmed. She stated he had not informed her he wanted his fingernails trimmed. She stated she thought she trimmed them on the previous Friday, and she didn't realize they were as long as they were. On 8/20/2026 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated she observed Resident #2's fingernails, and they were dirty and long. The DON stated the resident could cut himself with his fingernails and cause an infection. She stated it was her expectation that residents' fingernails be kept clean and trimmed. Record review of the Admission Record revealed Resident #2 was admitted to the facility on 3/05/2026 with medical diagnoses that included Parkinson's Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/10/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 03, indicating Resident #2 was severely cognitively impaired.			M0610			

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M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level IIBased on observation, interview, record review, and facility policy review, the facility failed to provide adequate supervision and implement effective, individualized interventions to prevent repeated falls for one (1) of two (2) resident reviewed for accidents and supervision. Resident #8 Findings include: Review of the facility policy titled "Fall Standard" with a revision date of 05/26 revealed under "Standards of Practice: The facility strives to reduce the risk for falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence..." An observation of Resident #8 on 08/17/26 at 1:30 PM revealed the resident was in the dayroom, standing up from his wheelchair taking three steps, while his legs were unsteady and beginning to buckle. No staff were present or close enough to assist the resident. The Survey Agency (SA) notified staff, and the resident was assisted back into his wheelchair, toileted and taken back into the day room/yellow room where staff tilted his wheelchair back approximately 45 degrees and elevated his legs and there were no staff present. Record review of the "Fall Reports" revealed the following falls from 11/2025 through 7/2026: On 11/08/25 at 19:30 (7:30 PM): During medication pass, staff heard a noise and found the resident standing beside the bed. The resident fell onto his buttocks and then onto his back. He stated he was trying to get into his chair. Staff assessed the resident, noted no injury, assisted him back to bed, and obtained vital signs. Staff instructed him to use the call light, placed the bed in the low position, and placed the call light within reach. Review of the			M0640			

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M0640	Continued from page 3 post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 11/09/25 at 18:00 (6:00 PM): The resident was found on the floor in his room, lying on his left side. He reported that his head was spinning. Staff assessed the resident, noted no skin issues, assisted him back to his wheelchair, obtained vital signs, and initiated neurological checks. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 12/14/25 at 20:45 (8:45 PM): While trying to get up to use the bathroom, the resident stumbled, struck his head on the wall, and fell onto his left side. He reported severe left hip pain and stated, "My hip is broken." His pain was documented as 10/10. The resident was sent to the emergency room. Post-incident documentation identified an abrasion and a left trochanteric (hip) fracture. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 01/14/26 at 00:55 (12:55 AM): The resident was found on the floor in his room after attempting to get up to go to the bathroom. He reported falling and striking his side on the bottom rail of the bed. He reported side and hip pain. The resident was sent to the emergency room for an X-ray evaluation. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/05/26 at 21:38 (9:38 PM): While transferring from the bed to his wheelchair, the resident slipped from the wheelchair and sat on the floor. He stated, "I slipped out of my wheelchair." Staff assisted him back to the wheelchair and then to bed. The assessment documented no injury or pain. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/09/26 at 09:20 (9:20 AM): The resident was found on the floor in front of the bathroom door after attempting to go to the bathroom and falling onto his knees. He reported buttock pain, and an abrasion was noted on his right knee. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/11/26 at 01:00 (1:00 AM): The resident was	M0640					

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M0640	Continued from page 4 found on the floor after attempting to use the urinal. He landed on his right side and sustained a small abrasion to his right elbow. Staff assessed the resident, provided first aid, returned him to bed, and encouraged him to call for assistance. The bed was in the low position, and the call light was within reach. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/11/26 at 15:30 (3:30 PM): While at the nurses' station, the resident fell onto his left elbow while attempting to get tools to fix his truck. Staff transferred him back to his wheelchair with two-person assistance and obtained vital signs. Redness was noted, and no pain was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/12/26 at 17:35 (5:35 PM): The resident was observed on the floor with his head near the bathroom. He stated he was trying to use the bathroom. Staff returned him to his wheelchair with two-person assistance. A skin tear was documented on his right elbow. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/13/26 at 11:00 (11:00 AM): The resident got out of his wheelchair and fell in his room while "Attempting to go home." A head-to-toe assessment identified a skin tear and bruising to his left elbow and bruising to his left rib area. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/18/26 at 06:00 (6:00 AM): After reporting chest pain earlier that morning, the resident was found on the floor in his room and stated, "I just fell in the floor." A skin tear was noted on his right upper forearm. Two certified nursing assistants (CNAs) returned him to bed using a Hoyer lift. The report stated he was sent to the emergency room based on nursing judgment. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 03/08/26 at 13:10 (1:10 PM): The resident entered another resident's room and fell at the bathroom door. Resident was found on his right side. Staff assessed him for redness, skin issues, and pain; none were documented. He was assisted			M0640			

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M0640	Continued from page 5 back to his wheelchair. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 03/14/26 at 23:15 (11:15 PM): The resident's roommate found him beside the bed after a fall. The resident stated he was going to see his brother. An abrasion to his right elbow was documented and treated. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/14/26 at 19:00 (7:00 PM): A nurse observed the resident standing before he fell near the end of his bed. When asked what he was trying to do, the resident stated, "I was trying to get to my car." Staff completed an assessment and obtained vital signs. No pain or injury was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/15/26 at 14:00 (2:00 PM): Housekeeping notified nursing that the resident had fallen in the shower room. He was found sitting on his left side, with his legs behind him, leaning against a wheelchair and positioned between two wheelchairs. He was unable to describe the fall. Staff assessed him and obtained vital signs. The resident denied pain, and no new skin issue was documented. Two staff members assisted him into his wheelchair, and neurological checks were initiated. The record did not indicate that staff were present in the shower room or explain how the resident accessed the locked shower room. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/25/26 at 07:15 (7:15 AM): The resident was found on the floor at the nurses' station. The report stated he had wanted to use the bathroom much of the night and morning despite having a catheter. The resident stated he was trying to go to the bathroom. Staff returned him to his wheelchair. An abrasion to his right upper arm was cleaned and dressed. A pain score of 8 and stomach pain were documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/27/26 at 14:40 (2:40 PM): The resident was observed in the hallway near his wheelchair after another staff member reported seeing him fall. The report stated he landed on his right side and struck			M0640			

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M0640	Continued from page 6 his head. Staff obtained vital signs and assessed his level of consciousness. An order was obtained to send him to the emergency room because he struck his head. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/01/26 at 10:00 (10:00 AM): The resident was observed sitting on the floor in the lounge/yellow room while holding onto a recliner and positioned between his wheelchair and the recliner. He stated, "I was trying to sit down." Two staff members returned him to his wheelchair. No injury, pain, or new skin issues were documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/19/26 at 17:00 (5:00 PM): The resident was observed on the day-room floor between his wheelchair and a sofa chair after attempting to transfer himself from the wheelchair to the chair. Two CNAs assisted him back to his wheelchair. No skin issue, loss of consciousness, or change in range of motion was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/20/26 at 19:15 (7:15 PM): The resident was observed on the floor in the yellow room/day room with a quarter-sized area documented on the left back side of his head. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/23/26 at 13:30 (1:30 PM): At the nurses' station, the resident leaned forward in his wheelchair and slid onto the floor. He was unable to provide details of the event. A head-to-toe assessment was completed, and no apparent injury was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 07/19/26 at 10:00 (10:00 AM): The resident was observed lying on his right side on the floor in the yellow room. He experienced right hip and lower back pain and was transferred to the hospital for evaluation. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. An interview with Certified Nurse Aide (CNA) #3 on 08/19/26 at 10:10 AM revealed she knew Resident			M0640			

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M0640	Continued from page 7 #8 was at risk for falls but stated he had not fallen during her shift. She stated he liked to sit up in his wheelchair and watch westerns, so he usually stayed in the dayroom. CNA #3 stated staff rounded on the resident every two hours and kept his bed in the lowest position when he was in bed. She confirmed he was unable to use the call light because of his impaired memory. She stated a camera was in the dayroom so that staff could watch the residents when they were at the desk charting. She confirmed staff were not always present at the desk to visualize the camera and revealed it probably would be best to have him located in an area where staff could visualize him closely. An interview with Registered Nurse (RN) #1 on 08/19/26 at 10:15 AM revealed Resident #8 had a lot of falls. She stated the resident was falling a lot because he had urinary frequency. RN #1 stated his falls had reduced since he had a recent suprapubic catheter inserted, and confirmed he frequently attempted to get up without assistance because of urinary frequency. She confirmed a scheduled toileting program had not been initiated by the facility. An interview with the Director of Nursing (DON) on 08/20/26 at 11:40 AM revealed Resident #8's falls were reviewed in the morning meetings. She explained that most of his falls were due to him wanting to go to the bathroom. She stated staff would take him, but he would not do anything, and after getting back in his wheelchair, he would want to go again. The DON stated his falls were due to his "disease process". She stated they had provided him with activity boards, done one-on-one activities, moved him closer to the nurse's station and therapy referrals. She confirmed she did not have documentation showing the facility had completed a root-cause analysis of the resident's falls or any documentation the falls were reviewed in high-risk meetings. When asked specifically about the 04/15/26 fall, when housekeeping notified nursing that Resident #8 was on the shower-room floor and the record did not indicate that staff were present, the DON stated, "I don't know what happened." She confirmed she did not investigate the incident to try and determine if staff were present or how the resident accessed the locked shower room or came to be on the floor. She stated, "I am doing so many other jobs; I don't have time." She confirmed she did not consistently follow through on the residents' falls. The DON confirmed that the facility had failed to provide adequate supervision to prevent numerous falls with Resident #8.			M0640			

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M0640	Continued from page 8 Record review of the "Admission Record" revealed the facility admitted Resident #8 on 11/05/25 with medical diagnoses that included Alzheimer's Disease, History of Falling, Benign Prostatic Hyperplasia with lower urinary tract symptoms, and Displaced Fracture of Base of Neck of Left Femur. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/01/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #8 was severely cognitively impaired.	M0640					
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to allocate and monitor all sources of fluid to ensure one (1) of three (3) residents reviewed for dialysis remained within the physician-ordered fluid restriction. Resident #4 Findings include: Record review of the facility policy titled "Renal Dialysis Management," revised 8/21, revealed under "Procedure: The facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice..." Record review of Resident #4's "Order Details" revealed an order dated 8/12/25, "Dialysis in "Proper name of city" every (M/W/F) (Monday, Wednesday, and Friday)" with a chair time of 12:30 PM. Record review of Resident #4's August 2026 Medication Administration Record (MAR) revealed an order dated 4/21/26 for a fluid restriction of 32 ounces (946 milliliters [mL]) every 24 hours. The MAR also revealed an order dated 2/16/26 for	M0655					

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M0655	Continued from page 9 "Nepro with lunch and supper three times a day," scheduled at 8:00 AM, 12:00 PM, and 5:00 PM. The three scheduled 240-mL Nepro supplements totaled 720 mL (approximately 24 ounces), leaving approximately 226 mL (8 ounces) for all other fluids during the 24-hour period. An observation of Resident #4's breakfast meal on 8/18/26 at 8:38 AM revealed staff offered the resident 240 mL of Nepro, 240 mL of milk, 240 mL of coffee, and 120 mL of apple juice, for a total of 840 mL (approximately 28 ounces). The resident was also scheduled to receive two additional 240-mL Nepro supplements later that day, in addition to fluids offered with lunch and dinner. An observation of Resident #4's breakfast meal on 8/20/26 at 8:10 AM revealed staff offered the resident 240 mL of Nepro, 240 mL of milk, 120 mL of cranberry juice, and 120 mL of orange juice, for a total of 720 mL (approximately 24 ounces). The resident was also scheduled to receive two additional 240-mL Nepro supplements later that day, in addition to fluids offered with lunch and dinner. During an observation and interview on 8/20/26 at 8:21 AM, Registered Nurse (RN) #1 confirmed Resident #4 was receiving a large amount of fluid with breakfast and was on a 32-ounce fluid restriction. RN #1 stated, "We need to get his fluid restriction clarified." RN #1 confirmed the fluids offered with meals and the Nepro ordered three times daily could easily exceed the resident's fluid restriction and cause fluid accumulation. A telephone interview with the Registered Dietitian (RD) on 8/20/26 at 8:42 AM revealed she spoke with the dialysis RD monthly and reviewed Resident #4's dialysis laboratory results. The RD stated the resident's albumin was low, so she increased the Nepro from twice daily to three times daily. When asked about the three daily Nepro supplements leaving approximately eight (8) ounces for all other fluids during the 24-hour period, the RD stated, "I see what you're saying." The RD confirmed she had not completed a fluid allocation for dietary and nursing staff. She further confirmed the fluid restriction should be strictly monitored to prevent excess fluid intake and related complications. Record review of Resident #4's meal ticket revealed "CCHO Renal, (Consistent carbohydrate diabetic diet with renal restrictions) FR, (Fluid restriction) Reg (Regular texture), DBL PT (Double protein portions)," with Nepro listed under preferences. The meal ticket did not identify the amount of fluid dietary staff			M0655			

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M0655	Continued from page 10 could provide with each meal or account for the 720 mL of Nepro scheduled each day. Record review of Resident #4's August 2026 MAR revealed an order dated 7/11/25 to "Record intake and output every shift." The documentation did not contain a complete, combined 24-hour total of fluids received from meals, Nepro supplements, medication administration, and other sources to show that the resident remained within the ordered 32-ounce daily fluid restriction. An interview with Certified Nurse Aide (CNA) #3 on 8/20/26 at 9:10 AM revealed Resident #4 usually received 240 mL of milk, 120 mL of juice, and 240 mL of coffee with breakfast, and 240 mL of tea with lunch and dinner. An interview with the Director of Nursing (DON) on 8/21/26 at 10:48 AM confirmed Resident #4's fluid intake was not tracked to include fluids received with meals, medications, supplements, and other sources. She stated the failure to track all fluid sources could result in excess fluid accumulation. Record review of Resident #4's "Admission Record" revealed the facility readmitted Resident #4 on 5/22/26 with diagnoses that included Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/8/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 12 under Section C, indicating Resident #4 was moderately cognitively impaired.	M0655					
M0935	45.32.2 Kitchen Kitchen. 1. Size and Dimensions. The minimum area of kitchen (food preparation only) for less than twenty-five (25) beds shall be a minimum area of two hundred (200) square feet. In facilities with twenty five (25) beds to sixty (60) beds, a minimum of ten (10) square feet per bed shall be provided. In facilities with sixty-one (61) to eighty (80) beds, a minimum of six (6) square feet per bed shall be provided for each bed over sixty (60) in the home. In facilities with eighty-one (81) to one hundred (100) beds, a minimum of five (5) square feet per bed shall be provided for each bed over eighty (80). In facilities with more than one hundred (100) beds proportionate space approved by the licensing	M0935					

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M0935	Continued from page 11. agency shall be provided. Also, the kitchen shall be of such size and dimensions in order to: a. Permit orderly and sanitary handling and processing of food. b. Avoid overcrowding and congestion of operations. c. Provide at least three (3) feet between working areas and wider if space is used as a passageway. d. Provide a ceiling height of at least eight (8) feet. 2. Equipment. Minimum equipment in kitchen shall include: a. Range and cooking equipment. Facilities with more than twenty-four (24) beds shall have institutional type ranges, ovens, steam cookers, fryers, etc., in appropriate sizes and number to meet the food preparation needs of the facility. The cooking equipment shall be equipped with a hood vented to the outside as appropriate. b. Refrigerator and Freezers. Facilities with more than twenty-four (24) beds shall have sufficient commercial or institutional type refrigeration/freezer units to meet the storage needs of the facility. c. Bulletin Board. d. Clock. e. Cook's table. f. Counter or table for tray set-up. g. Cans garbage (heavy plastic or galvanized). h. Lavatories, hand washing; conveniently located throughout the department.	M0935					

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M0935	Continued from page 12 i. Pots, pans, silverware, dishes, and glassware in sufficient numbers with storage space for each. j. Pot and Pan Sink. A three compartment sink shall be provided for cleaning pots and pans. Each compartment shall be a minimum of twenty-four (24) inches by twenty (24) inches by sixteen (16) inches. A drain board of approximately thirty (30) inches shall be provided at each end of the sink, one to be used for stacking soiled utensils and the other for draining clean utensils. k. Food Preparation Sink. A double compartment food preparation sink shall provide for washing vegetables and other foods. A drain board shall be provided at each end of the sink. l. Ice Machine. At least one ice machine shall be provided. If there is only one (1) ice machine in the facility it shall be located adjacent to but not in the kitchen. If there is an ice machine located at nursing station, then ice machine for dietary shall be located in the kitchen. m. Office. An office shall be provided near the kitchen for the use of the food service supervisor. As a minimum, the space provided shall be adequate for a desk, two chairs and a filing cabinet. n. Coffee Tea and Milk Dispenser. (Milk dispenser not required if milk is served in individual cartons). o. Tray assembly line equipment with tables, hot food tables, tray slide, etc. p. Ice Cream Storage. q. Mixer. Institutional type mixer of appropriate size for facility. r. Food Processor. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review the facility failed to	M0935					

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M0935	Continued from page 13 ensure the three-compartment sink was operational and available to sanitize dishes that could not be accommodated in the dishwasher for one (1) of three (3) kitchen tours. Findings Include: Review of the facility policy titled "Work Order Standard" revealed under, "Standard: It shall be the standard of this facility to process work orders timely in order to provide a safe and functional environment...Procedure: 1. When there is something identified as in need of repair, a concern noted with a piece of equipment or a malfunction in a piece of equipment, the person identifying the concern must report it to their supervisor. 2. The supervisor will then enter the work order into the work order log..." Review of the facility policy titled "Manual Warewashing," revised 11/19, revealed under, "Standard: Dining service pots and pans that cannot fit in a dish machine are clean and sanitized in a three-compartment sink..." During an observation of an attempted demonstration of the three-compartment sink with Dietary Staff #3 on 8/19/26 at 8:32 AM, she revealed the sink did not work and had been out of service for almost a year. She stated the wash and rinse compartments would not hold water. When the water was turned on, it immediately drained through the floor drain. Dietary Staff #3 revealed maintenance was aware of the problem and had been notified but had not repaired the sink. An interview with the Administrator on 8/19/26 at 8:48 AM revealed he had not been notified that the three-compartment sink was not working. An interview with the Dietary Manager (DM) on 8/19/26 at 11:06 AM confirmed the three-compartment sink was not operational and stated, "It hasn't been out that long." She stated she had told maintenance every day since the sink stopped working but could not recall whether she entered a work order. The DM stated she had also notified the Administrator. When asked what kitchen staff would do to sanitize dishes if the dishwasher malfunctioned or if something was too large to place in the dish machine, she stated, "I don't know." An interview with Maintenance on 8/19/26 at 11:16 AM revealed this was the first time he had heard that the three-compartment sink was not working. He confirmed he had not been notified and confirmed			M0935			

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M0935	Continued from page 14 that the facility used TELS (electronic work order system) for repairs and confirmed he had not received any repair requests for the kitchen. Record review of the June through August 2026 "Work Orders" revealed no evidence that a work order was submitted for the three-compartment sink. An interview with the Administrator on 8/20/26 at 9:48 AM confirmed it was the Dietary Manager's responsibility to ensure malfunctioning kitchen equipment was reported to maintenance for timely repair. He confirmed the three-compartment sink was essential for properly sanitizing larger dishes that could not fit in the dishwasher.		M0935				
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level IIBased on observation, interview, record review, and facility policy review, the facility failed to implement infection prevention and control practices for one (1) of four (4) care areas observed, specifically related to maintaining the urinary drainage system off the floor and following		M1570				

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M1570	Continued from page 15 Enhanced Barrier Precautions during catheter care for Resident #7. Findings include: Record review of the facility policy titled "Incontinence Management - Indwelling Catheters" revised 01/2020, revealed, "...Indwelling Catheter Care...To promote hygiene, comfort, and reduce migration of infectious organisms to the bladder...Procedure...2. The urinary drainage bag will be maintained off the floor at all times...4. The drainage bag will not be placed directly on the floor, including during resident care, transfers, repositioning, transportation, toileting, bathing, or environmental services...At no time should a urinary drainage bag be intentionally placed or allowed to remain on the floor..." Record review of the facility policy titled "Enhanced Barrier Precautions" dated 05/2024, revealed, "...Enhanced barrier precautions (EBP) should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk...Resident Status...Has a wound or indwelling medical device, without secretions or excretions that are able to be covered or contained...Use EBP...Yes..." Record review of Resident #7's Order Summary Report revealed an active order dated 05/29/2026 for Foley Catheter 14 French 10 cubic centimeters (cc) bulb Diagnosis: Neuromuscular Dysfunction of Bladder, unspecified. Record review of Resident #7's Care Plan Report revealed Resident #7 was on Enhanced Barrier Precautions related to Foley catheter initiated 3/10/2026. During the initial tour on 08/17/2026 at 10:45 AM, Resident #7's urinary catheter drainage bag was observed lying on the floor. During an interview on 08/17/2026 at 10:56 AM, Certified Nursing Assistant (CNA) #2 confirmed that Resident #7's catheter drainage bag was lying on the floor. CNA #2 stated the drainage bag should not touch the floor because of infection-control concerns. During an interview on 08/18/2026 at 8:51 AM, the Director of Nursing (DON) confirmed that Resident #7's catheter drainage bag should not have been on the floor because the practice increased the risk for	M1570					

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M1570	Continued from page 16 infection. On 08/19/2026 at 9:58 AM, CNA #1 was observed providing catheter care to Resident #7 without wearing a gown as required under Enhanced Barrier Precautions and as noted by EBP signage posted on the door entering the room. During catheter care, CNA #1 touched the resident's bed remote with the same gloves used to provide catheter care without removing the gloves and performing hand hygiene. CNA #1 confirmed that she should have worn a gown and should not have touched environmental surfaces with the gloves that were used during catheter care. During an interview on 08/19/2026 at 10:21 AM, the DON confirmed that CNA #1 should have worn a gown and gloves under Enhanced Barrier Precautions during catheter care. The DON further confirmed that CNA #1 should have removed the soiled gloves and performed hand hygiene before touching other items in the resident's room. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 7/1/26 with a medical diagnosis that included Relapsing-Remitting Multiple Sclerosis and Neuromuscular Dysfunction of Bladder. Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, indicating Resident #7 had moderate cognitive impairment.			M1570			