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 **10/01/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULFPORT CARE CENTER	**11240 CANAL ROAD , GULFPORT, Mississippi, 39503**

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M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey along with four (4) Complaint Investigations (CI MS #3168614, CI MS #3171421, CI MS #3176192 and CI MS #3204980) at the facility from 9/28/26 through 10/01/26. CI MS #3168614 was investigated for discharge process and CI MS #3176192 for nursing services and treatment and there were no citations related to these complaints. CI MS #3171421 was investigated for accidents/falls and cited M640. MS #3204980 for quality of care and wound care and cited M615. 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 M225, M500, and M1570.	M0000		
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.	M0225		

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

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M0225	Continued from page 1 c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on interviews, record review, and facility policy review, the facility failed to comply with state nursing facility staffing requirements by failing to designate a licensed nurse to serve as the Charge Nurse responsible for supervision of the total nursing activities in the facility, separate from the medication/treatment nurse assignment, from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM, for two (2) of three (3) shifts reviewed for charge nurse supervision. Findings include: A record review of the facility's policy titled "Nursing Services-Staffing" dated 02/2026 revealed	M0225		

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M0225	Continued from page 2 "…The facility will comply with established staffing requirements by the individual state governing agencies. Each facility will designate a nurse who holds an active license…as a Charge Nurse…" A record review of the facility's daily staffing records for 09/29/2026 and 09/30/2026 revealed the facility did not designate a Charge Nurse separate from the medication/treatment nurse from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM. On 09/30/2026 at 1:45 PM, during an interview, the Assistant Director of Nursing (ADON) stated she works Monday through Friday from 8:00 AM until 4:30 PM. The ADON stated she serves as the Charge Nurse when she is on duty. The ADON noted that when she is not on duty a cart nurse is assigned to work as the charge nurse as well as maintain the medication cart. On 10/01/2026 at 8:07 AM, during an interview, Certified Nursing Assistant (CNA) #2 stated she works 7:00 AM until 7:00 PM. The CNA reported that the cart nurse is the charge nurse. The CNA stated that in the event she needed supervisory assistance she would go to the cart nurse for help. On 10/01/2026 at 8:36 AM, during an interview, the Director of Nursing (DON) stated that the presence of a designated Charge Nurse would lend better care to the residents. The DON affirmed that the facility is actively looking to hire someone to fill the role of Charge Nurse for the uncovered hours. On 10/01/2026 at 1:17 PM, during an interview, the Administrator stated she was informed the facility was not in compliance with state staffing requirements because a Charge Nurse separate from the medication/treatment nurse was not designated from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM. The Administrator stated the importance of having a designated Charge Nurse was to provide an additional supervisory resource.	M0225		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's	M0500		

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M0500	Continued from page 3 responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M0500		

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M0500	Continued from page 4 transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M0500		

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M0500	Continued from page 5 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents' rights to a safe, clean, comfortable, and homelike environment were maintained by failing to: 1) ensure a resident's over-the-bed light was accessible for independent use despite requests for repair; and 2) ensure blood-soiled bed linens were changed timely after staff became aware of the soiled linens, for two (2) of 18 sampled residents. Residents #67 and #77. Findings include: A record review of the facility's policy titled "Resident Rights Policy" review date 05/2026 revealed "Every resident in this facility has the right to: … 8. Receive a prompt response to all requests and inquires …" A record review of the facility's policy titled "Infection Control," revision date 04/2026 revealed "…The facility shall maintain a comprehensive Infection Prevention and Control Program designed to provide a safe, sanitary and comfortable environment in which residents reside with minimal risk for the development and transmission of infections and communicable diseases…"	M0500		

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M0500	Continued from page 6 Resident #67 A record review of Resident #67's "Face Sheet" revealed the facility admitted the resident initially on 07/21/2016 and re-entry on 01/16/2021 with diagnoses including Essential (Primary) Hypertension and Acute Kidney Failure, Unspecified. A record review of Resident #67's "Comprehensive Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/08/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated cognitively intact. Section GG0170 revealed that Resident required partial/moderate assistance with sit to stand and chair/bed-to-chair transfers. On 09/28/2026 at 12:12 PM, during an observation and interview, Resident #67 was observed sitting on the side of his bed eating lunch. Resident #67 stated he had repeatedly reported to staff that his over-the-bed light needed a pull cord and a replacement light. The resident stated the pull cord had been missing for approximately nine (9) months, preventing him from independently turning the light on and off. The State Agency (SA) observed the resident's over-the-bed light did not have a pull cord, while his roommate's light had a pull cord. On 09/28/2026 at 2:54 PM, during an interview, Certified Nurse Aide (CNA) #5 confirmed Resident #67's over-the-bed light did not have a pull cord. On 09/29/2026 at 1:40 PM, during an interview and observation, Resident #67 was sleeping in bed with head covered. The SA observed the over-the-bed light did not have a pull cord. Resident reported that he has told Maintenance and the other staff he needs a string to turn on his light. He explained he is unable to reach the light switch to turn it on or off and has to ask staff to turn on light each time he eats. On 09/29/2026 at 2:10 PM, during an interview, CNA #3 stated that Resident #67 asked to have the light above his bed turned on when he ate yesterday and today. She confirmed there was no cord for him to pull to turn the light on. Today is only her second day working with Resident #67, but he can stand and transfer to his wheelchair and takes himself to the bathroom but is not able to stand for long periods of time. Resident asks for assistance when needed. On 09/29/2026 at 2:45 PM, during an interview, the	M0500		

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M0500	Continued from page 7 Maintenance Director stated he had been aware that Resident #67's over-the-bed light had been missing the pull cord for approximately two (2) months. The Maintenance Director stated the light could only be operated using the switch located on the light fixture. He stated he contacted the supply store on 09/24/2026 regarding a replacement pull cord and was informed the item was on order; however, he could not provide documentation verifying the order. The Maintenance Director stated maintenance concerns were reported verbally by staff, and the facility did not maintain a log of maintenance requests or repairs. He stated he reported to work at 6:00 AM five (5) days per week to communicate with night- and day-shift staff regarding maintenance concerns. On 09/29/2026 at 3:25 PM, during an interview, CNA #4 stated that Resident #67 mostly sleeps all the time. She reported that he doesn't like the lights on unless he is eating his meals. She confirmed that there has not been a cord or string attached to his over the bed light since she has been working at the facility for two (2) months. Resident #77 A record review of Resident #77's “Face Sheet” revealed the facility admitted the resident initially on 03/19/2026 and re-entry on 07/02/2026 with diagnoses including Chronic Kidney Disease, Stage 3a, Obstructive and Reflux Uropathy, Unspecified, and Methicillin Resistant Staphylococcus Aureus Infection as The Cause of Diseases Classified Elsewhere added 9/10/2026. A record review of Resident #77's “Discharge Minimum Data Set (MDS)” with an Assessment Reference Date (ARD) of 08/30/2026 revealed Section C1000 revealed resident is independent for cognitive skills for daily decision making. On 09/29/2026 at 2:00 PM, during an interview, Licensed Practical Nurse (LPN)#5 stated that Resident #77's PICC (peripherally inserted central catheter) line is being assessed via the PICC line nurse currently due to the site had been bleeding. On 09/29/2026 at 3:23 PM, during an observation of catheter care provided to Resident #77 by Certified Nurse Aide (CNA) #3, with assistance from CNA #6, the State Agency (SA) observed bright red blood on the fitted sheet on the right side of the resident's bed and on the outer tape of the resident's peripherally inserted central catheter (PICC) line dressing.	M0500		

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M0500	Continued from page 8 On 09/29/2026 at 3:55 PM, during an interview and observation with LPN #2, she explained resident #77 had been in and out of the hospital since being admitted. She reported that resident was currently on contact isolation related to MRSA in urine. Blood remained on the fitted sheets. LPN reported the PICC line was assessed today and the line was out two (2) centimeters, and a new dressing was put in place today. She confirmed the blood on the sheet and on the PICC line outer tape. On 09/30/2026 at 7:40 AM, during an observation and interview, Resident #77 was observed lying in bed with dried blood remaining on the fitted sheet. The resident's PICC line dressing had a scant amount of dried blood at the insertion site and dried blood on the outer tape. Registered Nurse (RN) #2 stated the PICC line had been bleeding since Monday and had been assessed the previous day. Resident #77 confirmed the blood had remained on the fitted sheet and outer tape since the previous day. The resident stated he did not like lying in blood, especially after experiencing multiple infections. RN #2 removed the blood-soiled outer tape. On 09/30/2026 at 8:45 AM, during an observation with RN #2, the SA observed RN #2 remove the intravenous antibiotic tubing and flush the PICC line. Blood remained on the resident's fitted sheet. On 09/30/2026 at 11:05 AM, during an observation and interview, Resident #77 stated staff had not changed his bed linens. He reported that his PICC line finally had not been bleeding any more. He explained he knows that the staff is busy and may not have had a chance to change his bed. On 09/30/2026 at 1:30 PM, during an observation and interview of Resident #77, he reported that he is not feeling good and will be going out to the hospital. Blood continued to be on the sheet, resident reported that he guesses the sheet will get changed when he goes to the hospital. On 10/01/2026 at 2:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated Resident #77 remained on Contact Precautions following his return from the hospital. LPN #5 stated staff were expected to change bed linens when they became soiled or blood was observed. LPN #5 stated she changed Resident #77's bed linens while the resident was at the hospital. On 10/01/2026 at 3:00 PM, during an interview with	M0500		

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M0500	Continued from page 9 the Director of Nursing (DON), she confirmed any resident with soiled linen or bloody linen should have the linens changed. All residents should feel they are in a safe, sanitary, and comfortable home-like environment and have all residents' rights to be honored. On 10/01/2026 at 3:30 PM. during an interview with the Administrator, she reported that she expects all staff to follow Contact Precaution guidelines, honor residents' rights including a safe, sanitary, and comfortable homelike environment ensuring resident rooms have proper working equipment. She reported resident #67 could have been moved to another room until his light was properly working.	M0500		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on interviews, record review, and facility policy review, the facility failed to provide necessary treatment and services to prevent the avoidable deterioration of a facility-acquired pressure injury for one (1) of two (2) residents reviewed for pressure injuries. The facility failed to accurately identify and reassess a deteriorating left elbow wound as a pressure injury, ensure timely provider evaluation in response to documented wound deterioration, and implement the wound care Nurse Practitioner's (NP's) recommendation for daily dressing changes. The resident's left elbow wound, initially documented as a skin tear, deteriorated to an unstageable pressure injury with extensive slough and eschar. Following transfer to the hospital for left arm and abdominal swelling, the resident underwent surgical debridement of the left elbow wound, bone biopsy, and wound vacuum placement. Resident #33. Findings include: A record review of the facility's policy titled “Prevention and Treatment of Skin Issues,” reviewed 05/2026, revealed “… It is the policy to identify and assess residents whose clinical conditions place	M0615		

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M0615	Continued from page 10 them at increased risk for impaired skin integrity and pressure ulcers. The facility shall implement appropriate preventative interventions and provide evidence-based treatment modalities for wound care in accordance with current industry standards and best practice … Prevention of Pressure Ulcers … C. Monitoring of Skin Integrity Skin integrity shall be routinely monitored during daily care by nursing staff. Any changes in skin condition shall be promptly reported, documented, and addressed in accordance with facility protocols … F. Additional Preventative Measures The following interventions may be implemented based on identified risk factors and individual resident needs: Pressure-reducing, relieving, or redistributing mattresses for resident beds … All findings, changes, or concerns shall be documented in the resident's clinical record … Notify the Physician/NP (Nurse Practitioner), Family and Supervisor/Designee if the skin issue has not shown progress in 2-4 weeks and/or is deteriorating …Resident Choice To support the resident's right to make informed decisions regarding care and treatment-including the right to refuse treatment-the facility shall discuss with the resident and/or legal representative … These discussions and decisions shall be documented in the resident's clinical record" A record review of Resident #33's "Face Sheet" revealed the resident was admitted on 07/30/2026 with diagnoses including quadriplegia and cervical spine fusion. A record review of the resident's "Braden Scales," dated 07/31/2026, 08/07/2026, 08/14/2026, 08/21/2026, and 09/14/2026, revealed the resident was identified as being at high risk for pressure ulcer development on each assessment. A record review of Resident #33's "Admission Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/06/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. Section M revealed one (1) Stage 2 pressure ulcer. A record review of the resident's "Discharge MDS," with an ARD of 09/15/2026, revealed one (1) Stage 3 pressure ulcer and one (1) unstageable pressure ulcer. A record review of Resident #33's "Progress Notes" revealed the left elbow wound was initially documented as a skin tear on 08/16/2026. Treatment orders were initiated to cleanse the wound, apply	M0615		

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M0615	Continued from page 11 Xeroform gauze, and cover with a dry border dressing three (3) times weekly and as needed. A record review of Resident #33's “Progress Notes” revealed the following progression of the left elbow wound: On 08/27/2026, the wound was documented as a skin tear measuring 1.78 centimeters (cm) in length, 1.54 cm in width, and 0.10 cm in depth, with 10% slough and moderate serosanguineous drainage. On 09/03/2026, the wound remained classified as a skin tear and measured 2.15 cm in length, 2.21 cm in width, and 0.10 cm in depth, with 60% slough and moderate serosanguineous drainage. On 09/10/2026, the wound remained classified as a skin tear and measured 2.36 cm in length, 1.97 cm in width, and 0.1 cm in depth, with 20% slough, 40% eschar, and moderate serosanguineous drainage. The assessments documented an increase in wound dimensions and the development of additional nonviable tissue while the wound continued to be classified as a skin tear. A record review of Resident #33's “Assessment” completed by the wound care NP, with a date of service of 09/11/2026, revealed the left elbow wound was identified as an unstageable pressure ulcer measuring 3.5 cm in length, 2.8 cm in width, and 0.1 cm in depth, with 76–100% slough and moderate exudate. The wound care NP recommended daily dressing changes and as needed. A record review of Resident #33's “Order Summary Report” revealed that following the wound care NP's assessment on 09/11/2026, the facility's treatment orders continued to identify the left elbow wound as a skin tear and directed dressing changes three (3) times weekly, rather than daily as recommended by the wound care NP. The treatment order dated 09/14/2026 continued to specify dressing changes on Monday, Wednesday, and Friday. A record review of Resident #33's “Treatment Administration Record (TAR)” for September 2026 revealed treatments for the left elbow wound were not documented as completed on 09/01/2026, 09/08/2026, 09/10/2026, and 09/14/2026. A record review of Resident #33's “View Progress Note” dated 09/11/2026 revealed the resident's family expressed concerns regarding a possible infection of the left elbow wound. The nursing	M0615		

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M0615	Continued from page 12 assessment documented swelling, odor, moderate serosanguineous drainage, and slough in the left elbow wound. The NP was notified, and the resident received orders for antibiotics. A record review of Resident #33's “Notice of Transfer/Discharge Notice” dated 09/15/2026 revealed the resident was transferred to the hospital for increased swelling of the abdomen and left upper extremity. A record review of Resident #33's hospital “Plastic Surgery Consultation” dated 09/15/2026 revealed “Reason for Consult: Left elbow wound…The wound is thought to be due to pressure injury sustained at the patient’s nursing home…X-ray and MRI (Magnetic Resonance Imaging) showed subtle subcortical irregularity in the olecranon concerning for early osteomyelitis…He is on vanc, Zosyn, and doxycycline…left elbow with 3 cm by 4 cm open wound on the proximal forearm overlying the ulna/distal olecranon with exposed tendon…” A record review of Resident #33's hospital “Orthopedic Consult Note” dated 09/16/2026 revealed the left elbow wound appeared to be full thickness with exposed bone. A record review of Resident #33's hospital “Operation Note” dated 09/28/2026 revealed the preoperative diagnosis was an open wound of the left elbow with suspected Stage IV pressure injury. The resident underwent sharp and blunt excisional debridement of skin and subcutaneous tissue measuring 3.5 cm by 4.5 cm, bone biopsy of the left olecranon, and wound vacuum placement. On 09/29/2026 at 9:35 AM, during a telephone interview, Resident #33's family member stated she observed wounds to the resident's buttocks and left elbow during a visit before his transfer to the hospital. She stated the resident's left arm was swollen and that he reported experiencing swelling and receiving pain medication. The family member expressed concerns regarding the residents' limited mobility and repositioning needs. On 09/29/2026 at 2:55 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated Resident #33 continued to complain of left arm pain despite receiving pain medication from the night-shift nurse on the day of his hospital transfer. LPN #3 stated she notified the NP of the resident's condition, and the resident was transferred to the hospital for evaluation.	M0615		

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M0615	Continued from page 13 On 09/30/2026 at 4:00 PM, during an interview, the Director of Nursing (DON) stated Resident #33 refused repositioning at times; however, the facility did not obtain a refusal-of-treatment form. The DON confirmed the resident had one (1) wound upon admission and subsequently developed additional wounds, including the left elbow wound. The DON stated that, due to the resident's quadriplegia and limited mobility, he would have benefited from a low air loss mattress. On 09/30/2026 at 4:30 PM, during an interview, the Physician stated he had been informed that Resident #33 refused repositioning and that it would be difficult to determine whether the wounds were unavoidable. The Physician stated he expected staff to implement preventive interventions to reduce the risk of skin breakdown and prevent deterioration of existing wounds. On 10/01/2026 at 2:20 PM, during an interview, the Assistant Director of Nursing (ADON) stated she completed her first assessment of Resident #33's left elbow wound on 08/27/2026. The ADON stated she believed she had reclassified the wound as a pressure injury; however, upon reviewing the assessments dated 08/27/2026, 09/03/2026, and 09/10/2026, she confirmed the wound remained documented as a skin tear despite deterioration and the presence of slough and eschar. The ADON acknowledged the wound had increased in size and deteriorated. She confirmed the wound care NP completed the first specialist assessment of the left elbow wound on 09/11/2026. The ADON further confirmed the wound care NP recommended daily dressing changes; however, the facility did not update the treatment orders, which remained three (3) times weekly. On 10/01/2026 at 3:05 PM, during an interview and record review, Registered Nurse (RN) #4 reviewed Resident #33's skin assessments and wound photographs dated 08/27/2026, 09/03/2026, and 09/10/2026. Following the review, RN #4 stated the left elbow wound was a pressure ulcer and should have been identified and addressed in the resident's care plan as a pressure ulcer. On 10/01/2026 at 3:00 PM, during an interview, the DON stated she had not personally assessed Resident #33's wounds but was aware the left elbow wound had deteriorated. The DON stated she was unable to locate documentation that the left elbow wound had been evaluated by a NP or physician before the wound care NP's assessment on 09/11/2026. The DON further stated she was	M0615		

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M0615	Continued from page 14 unaware that the wound care NP's recommendation for daily dressing changes had not been reflected in the facility's treatment orders. The DON stated she expected staff to accurately assess and document wounds, report changes in skin condition, and notify the NP or physician of identified skin concerns. On 10/01/2026 at 3:30 PM, during an interview, the Administrator stated she expected staff to follow the facility's policies and procedures regarding wound care and pressure ulcer prevention.	M0615		
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 II Based on interviews, record review, and facility policy review, the facility failed to ensure an assistive device necessary to prevent an avoidable accident was utilized when a Certified Nursing Assistant (CNA) transported a resident in a wheelchair without the required bilateral footrests, resulting in the resident's foot contacting the floor and the resident falling from the wheelchair, for one (1) of four (4) residents reviewed for accidents. Resident #75. Findings include: A record review of the facility's policy titled "Fall Risk Screening," revised 03/2026, revealed "…2. Interventions to improve strength, balance and mobility…should be implemented to reduce fall risk…" A record review of Resident #75's "Face Sheet" revealed the facility admitted the resident on 04/02/2025 with diagnoses including Primary Generalized (Osteo)Arthritis. A record review of Resident #75's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 06/19/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A record review of Resident #75's "Care Plan	M0640		

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M0640	Continued from page 15 Report" initiated 6/26/26 revealed a focus for risk of injury during wheelchair transport related to lower-extremity weakness, with interventions requiring bilateral leg rests to be in place and properly positioned whenever the resident was transported in a wheelchair and verification that the resident's feet were securely positioned on the leg rests before initiating wheelchair transport. A record review of the "Witnessed Fall" report, dated 08/19/2026, revealed Resident #75 stated, "I dropped my feet." A record review of Resident #75's "Portable Medical Diagnostics" bilateral knee X-ray reports revealed incomplete examinations with oblique lucencies identified in the distal femurs. The radiologist indicated that "distal femur fractures can be evaluated with diagnostic imaging." A record review of Resident #75's "Order Summary," dated 08/19/2026, revealed an order to "transfer to er (emergency room) for further evaluation." A record review of Resident #75's "Discharge MDS," with an ARD of 08/19/2026, revealed the resident was discharged to a short-term general hospital. A record review of the facility's investigation revealed Resident #75 was assessed following the incident and witnesses were interviewed. On 09/28/2026 at 11:45 AM, during an interview, Certified Nursing Assistant (CNA) #1 stated she worked at the facility from 07/29/2026 through 08/19/2026. CNA #1 stated that on 08/19/2026, she positioned Resident #75 in her wheelchair but could not locate the wheelchair footrests in the resident's room. CNA #1 stated she began transporting the resident down the 300-hall toward the dining room without the footrests attached to the wheelchair. CNA #1 stated that during transport, she noticed the resident's oxygen tank was low and notified a nurse, who instructed her to follow her to the oxygen storage room. CNA #1 stated she continued transporting Resident #75 behind the nurse. CNA #1 stated that as they approached the area near the dining room, Resident #75 placed her foot on the floor and fell from the wheelchair. CNA #1 stated she knew to review residents' care plans to identify their care needs. CNA #1 stated she did not receive an in-service following the incident and was told she was not at fault. On 09/28/2026 at 1:42 PM, during an interview, the	M0640		

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M0640	Continued from page 16 Certified Occupational Therapist Assistant (COTA) stated Resident #75 was receiving physical therapy before the fall on 08/19/2026. The COTA stated the resident had chronic extension of the lower extremities and experienced pain with minimal bending. The COTA stated Resident #75 lacked sufficient lower-extremity strength to maintain her legs in an elevated position independently and required wheelchair footrests. The COTA confirmed the resident's wheelchair was equipped with footrests. On 09/28/2026 at 2:03 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated that on 08/19/2026, CNA #1 was transporting Resident #75 in her wheelchair along the 300-hall. LPN #3 stated another staff member, whom she could not recall, asked her to obtain oxygen for the resident. LPN #3 stated that as CNA #1 and Resident #75 approached the area between the nursing station and dining room, the resident fell from the wheelchair. LPN #3 stated she could not recall whether the resident's wheelchair had footrests attached. On 09/29/2026 at 10:00 AM, during an interview, the Director of Nursing (DON) stated she was not employed at the facility at the time of the incident. The DON stated Resident #75 was transferred to the hospital following the incident and had not returned to the facility. The DON stated the resident had wheelchair footrests but was known to resist placing her feet on them. On 10/01/2026 at 8:51 AM, during an interview, the Administrator acknowledged the facility had not taken every reasonable measure to prevent the accident involving Resident #75. The Administrator stated the facility made efforts to provide staff with information regarding residents' care needs and emphasized the importance of providing quality care.	M0640		
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	M1570		

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M1570	Continued from page 17 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 II Based on observations, interviews, record review, and facility policy review, the facility failed to implement established Contact Precaution procedures to reduce the risk of transmission of infectious organisms when designated containers for the disposal of used personal protective equipment (PPE) and potentially contaminated linens were not available in a resident's room, and staff discarded used PPE in regular trash rather than the designated disposal containers required by the facility's procedures, for two (2) of four (4) days of survey. Resident #77. Findings include: A record review of the facility's policy titled "Infection Control," revised 04/2026, revealed "…The facility shall maintain a comprehensive Infection Prevention and Control Program designed to provide a safe, sanitary and comfortable environment in which residents reside with minimal risk for the development and transmission of infections and communicable diseases…" A record review of the facility's policy titled "Isolation Precautions and Duration for Specific Infections," reviewed 06/2026, revealed "The facility shall implement and maintain infection prevention and control practices consistent with current guidance issued by the Centers for Disease Control and Prevention (CDC), applicable state health department regulations and federal requirements …" A record review of the "Guideline for Isolation Precautions: Preventing Transmission of Infectious	M1570		

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M1570	Continued from page 18 Agents in Healthcare Settings (2007)," updated September 2024, revealed "…Contact Precautions are intended to prevent transmission of infectious agents…which are spread by direct or indirect contact with the patient or the patient's environment... Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission … Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination …" A record review of the facility's "In-service Training," dated 03/05/2026, revealed education addressing Enhanced Barrier Precautions and Contact or Droplet Precautions. The training instructed staff to remove PPE and place it in biohazard bags before exiting the room. The attendance record contained 26 staff signatures. A record review of Resident #77's "Face Sheet" revealed the facility initially admitted the resident on 03/19/2026, with re-entry on 07/02/2026, and diagnoses including Chronic Kidney Disease, Stage 3a; Obstructive and Reflux Uropathy, Unspecified; and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection as The Cause of Diseases Classified Elsewhere, added 09/10/2026. A record review of Resident #77's "Order Summary Report" revealed an active order dated 09/28/2026 for "Contact Precautions R/T (related to) MRSA Every Shift," with an end date of 10/13/2026. On 09/28/2026 at 10:57 AM, during an observation and interview, the State Agency (SA) observed Contact Isolation signage posted on Resident #77's door and Registered Nurse (RN) #1 applying personal protective equipment (PPE) before entering the resident's room. RN #1 stated Resident #77 was on Contact Precautions related to wounds, including a sacral wound. RN #1 stated staff were expected to wear PPE when entering the room and providing care. RN #1 stated the resident had a Peripherally Inserted Central Catheter (PICC) line for intravenous antibiotics, and she was assessing the PICC line. On 09/28/2026 at 11:05 AM, during an observation	M1570		

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M1570	Continued from page 19 and interview, the SA observed Resident #77 had an indwelling urinary catheter and a PICC line dressing with a moderate amount of blood beneath the dressing. No designated biohazard waste containers or contaminated linen receptacles were observed in the resident's room or bathroom. Discarded PPE was observed in a regular trash container in the bathroom. Resident #77 stated he had experienced repeated hospitalizations related to urinary tract infections and other infections. On 09/29/2026 at 9:05 AM, during an observation, the SA observed Contact Isolation signage remained posted on Resident #77's door, with PPE available at the entrance, hanging on the door. No designated biohazard waste containers were observed in the resident's room or bathroom. On 09/29/2026 at 10:25 AM, during an interview, Certified Nurse Aide (CNA) #3 stated she had worked at the facility for two (2) days and was completing required in-service education, including infection control. CNA #3 confirmed designated biohazard disposal containers were not available in Resident #77's room on 09/28/2026. CNA #3 stated she provided care to the resident and discarded used PPE in regular trash containers. CNA #3 stated she placed used linens in clear bags with other linens. CNA #3 stated she had not been instructed to place designated disposal containers in the resident's room. On 09/29/2026 at 2:20 PM, during an interview, CNA #4 stated Resident #77 was on Contact Precautions related to Methicillin Resistant Staphylococcus Aureus (MRSA) in his urine. CNA #4 stated designated cardboard biohazard containers were expected to remain in the resident's room. CNA #4 confirmed the containers were not present until after lunch on 09/29/2026. On 09/29/2026 at 3:00 PM, during an observation, the SA observed two (2) cardboard biohazard containers with red biohazard bags had been placed in Resident #77's room. On 09/29/2026 at 3:10 PM, during an interview, CNA #5 stated she assisted with Resident #77's care on 09/28/2026 and did not observe designated biohazard containers in the resident's room or bathroom. CNA #5 stated used PPE was discarded in regular trash containers and used linens were placed in clear bags with other linens in the collection bins. On 09/29/2026 at 3:55 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed	M1570		

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M1570	Continued from page 20 Resident #77 was on Contact Precautions related to MRSA in his urine. LPN #2 stated staff were expected to wear PPE when entering the resident's room and discard used PPE in designated biohazard containers located in the bathroom. LPN #2 confirmed the designated biohazard containers were not available on 09/28/2026 or during the morning of 09/29/2026. On 09/30/2026 at 7:40 AM, during an interview, RN #2 stated Resident #77 had been on Contact Precautions for more than one (1) month. RN #2 confirmed designated disposal containers had not been available in the resident's room during the preceding survey observations. RN #2 stated she obtained a bag outside the room to dispose of used PPE but did not place a designated container in the resident's room. RN #2 stated the Infection Preventionist was responsible for ensuring designated disposal containers were available. On 10/01/2026 at 2:00 PM, during an interview, LPN #5 stated Resident #77 had been on Contact Precautions for approximately two (2) months. LPN #5 stated designated biohazard containers were expected to be maintained in the resident's bathroom and replaced as needed. LPN #5 stated any staff member could replace the containers and that staff were expected to replace missing containers promptly. LPN #5 stated she was responsible for ensuring staff received infection control and PPE education, including laundry and housekeeping staff. LPN #5 stated she had been unable to monitor completion of all online training. On 10/01/2026 at 3:00 PM, during an interview, the Director of Nursing (DON) stated residents on Contact Precautions were expected to have designated disposal biohazard containers for potentially contaminated linens and biohazardous waste available in their rooms. The DON stated staff were expected to follow Contact Precaution procedures to prevent transmission of infectious organisms and confirmed nursing staff could obtain and place the required containers in residents' rooms. On 10/01/2026 at 3:30 PM, during an interview, the Administrator stated she expected staff to follow CDC Contact Precaution guidelines, ensure resident rooms were equipped with the supplies required to implement Contact Precautions, and promptly report missing infection control supplies.	M1570		