STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255130	A. BUILDING _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPPAH COUNTY NURSING HOME	1005 CITY AVENUE NORTH RIPLEY, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint investigation (CI) MS #26610 at the facility from 11/4/24 through 11/6/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA determined the facility was not in compliance for CI MS #26610 for physical environment and cited F584. The SA also cited F656 and F880 during the survey. The census at the time of the survey was 36 with a facility license for 40 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		12/19/24

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

Electronically Signed | 11/26/2024

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide a safe, functional, and sanitary environment for residents' use as evidenced by both facility's shower rooms being in disrepair for two (2) entrance areas of two (2) shower rooms in the facility. Findings include: Record review of facility's letterhead notification signed by the Administrator and dated 11/5/24, revealed, "(Proper name of facility) does not have a specific policy for environment of care, concerning walls, etc. A policy is being developed immediately." During interviews and a tour with the Administrator and the Director of Nursing (DON)	F 584	1. On 11/4/2024, Maintenance Director was verbally educated on the need for shower renovations as soon as possible. On 11/20/2024, Maintenance Director was notified that 2567 was received and both showers needed to be renovated and were due to be complete by 12/19/2024. Maintenance Director began renovation of East Shower on 11/21/2024. South Shower renovation to begin immediately following completion of East Shower. 2. All residents have the potential to be affected by this deficient practice.	

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F 584	Continued From page 2 on 11/4/24 at 3:55 PM, it was revealed that each of the two locked shower rooms had an entrance area from the resident hallways that led to the shower area. Upon entrance into each of these areas, damage to walls and ceilings was observed. In the east hall shower room, the outside corner of the wall where people would walk or be assisted in a chair to the shower area had a large open area of missing plaster with visible metal grill like material. The ceiling around an air vent was also noted to be damaged with some plaster hanging down and a black substance on the open areas of the ceiling. In the south hall shower room, the ceiling surrounding the air vent was noted to have a large amount of damage and opened areas to the plaster with a dark substance noted near those open areas. The area behind the door where the doorknob met the wall was noted to be damaged with a large hole of missing plaster and metal noted inside. The DON stated the location and the necessity to pass through this area to enter the shower could lead to the potential for an injury and the areas needed repair. The Administrator revealed the entrance area to each of the two shower rooms had not been remodeled. She stated it had been mentioned to the maintenance department, but it was not repaired. She stated there was the potential for an injury to occur from this and it needed to be repaired. She confirmed the facility failed to provide a safe, functional, and sanitary environment for the residents' shower areas. During an interview and walk through observation with the Maintenance Director on 11/6/24 at 1:50 PM, it was revealed that he was aware of the damaged areas in each of the shower rooms. He stated he had been unsuccessful in finding	F 584	3. On 11/12/2024, Maintenance Director created a policy titled Work Orders on how maintenance items are addressed concerning the environment of care. This policy was approved by Medical Director on 11/12/2024. This policy was presented to Quality Assurance Committee on 11/21/2024 and was approved. On 11/21/2024, Administrator created a policy titled Homelike Environment on maintaining a homelike environment. This policy was approved by Medical Director on 11/21/2024. This policy was presented to Quality Assurance Committee on 11/21/2024 and was approved. On 11/21/2024, 11/22/2024, and 11/26/2024, Maintenance Department, nursing staff, and facility department heads were in-serviced by Administrator on new policies titled Work Orders and Homelike Environment. 4. The Administrator developed a Quality Improvement Monitor on 11/21/2024 to be monitored daily times 29 days beginning 11/21/2024, then weekly times 4, then monthly times 1 year. Administrator will ensure that both shower rooms are in good working order, with no safety concerns and are as homelike as possible. Administrator added to facility Quality Scorecard on 11/21/2024. The Quality Assurance Committee will review monthly results beginning 12/19/2024 and make	

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F 584	Continued From page 3 someone to come in to do the necessary repairs, but he was attempting to contact another person to get the needed repairs completed. The Maintenance Director measured the damaged areas and in the east hall shower room, an area of an outer corner leading into the shower area measured approximately 22 inches from the top of the baseboard up the outer corner wall with a width of approximately 5 inches on one side of corner and 4 inches on the other side of the corner. This damaged area had a metal grill like material that was exposed. He confirmed the ceiling was missing plaster with open areas around air vent. This damaged area was measured approximately 25 inches x 18 inches with an open area with a black substance next to the air vent measuring approximately 8 inches by 1 inch. In the south hall shower room, the ceiling damage measured approximately 24 inches by 20 inches, with two open areas of a black substance next to the air vent measuring approximately 9 inches by 3 inches for one and approximately 2 inches by one inch for the other one. He stated he was unsure of what the dark substance on the open areas of ceiling was, but it could have been caused by the moisture. The area behind the south hall shower room door where doorknob met wall with an open area measuring approximately 5 inches by 4 inches with metal noted in the open area. The Maintenance Director confirmed he was aware of these damaged areas and that the areas needed to be repaired for safety.	F 584	recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	
F 656 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	F 656		12/19/24

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F 656	Continued From page 4	F 656		

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)-
(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.

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F 656	Continued From page 5 §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 staff interviews, record review, and facility policy review, the facility failed to develop a care plan for hospice service for one (1) of 14 sampled residents' care plans reviewed. Resident #15 Findings include: Record review of the facility policy titled, "MDS 3.0: Care Plans (Minimum Data Set)" dated 6/23/16, revealed, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 1. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being as required, 2. Any services that would otherwise be required." Record review of Resident # 15's physician's "Order Details" revealed an order dated 5/9/24 to "Admit to (proper name of hospice company) hospice." Record review of the care plans for Resident #15 revealed there was no care plan for hospice care and services. During an interview on 11/6/24 at 11:45 AM, the Minimum Data Set (MDS) Coordinator revealed	F 656	1. On 11/6/2024, MDS Coordinator initiated a hospice care plan on Resident #15. The care plan was entered into electronic health record and a hard copy was placed on Resident #15□s paper chart on 11/6/2024. On 11/21/2024, MDS Coordinator reviewed all residents receiving hospice services to ensure that all had a hospice care plan. All residents receiving hospice services had a hospice care plan. 2. 6 residents have the potential to be affected by this deficient practice. 3. On 11/6/2024, MDS Coordinator was verbally educated by Administrator on regulation F656, that a comprehensive care plan must be developed for residents and this includes hospice services. MDS Coordinator verbalized understanding and developed the care plan on 11/6/2024. On 11/22/2024, a copy of the F656 regulation and facility policy titled MDS 3.0: Care Plans (Minimum Data Set) was given to MDS Coordinator by Administrator for educational purposes to ensure that this regulation is met in the future. 4. The Administrator developed a Quality	

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F 656	Continued From page 6 Resident #15 was receiving hospice services and was assessed for hospice on the MDS assessment, but a care plan was not developed. She acknowledged any resident receiving hospice services should have a care plan for that care, and she was uncertain why this one was not done. She stated the resident had been on and off of hospice and this care plan just "slipped through the cracks" and was not done. An interview with the Administrator on 11/6/24 at 11:55 AM, confirmed Resident #15 was receiving hospice services, therefore, a care plan for this was needed. She stated that she was uncertain why the care plan was not developed. She acknowledged the care plan provided the staff with a guide for the care of each resident and should include the plans/treatments/preferences for each resident and the facility failed to develop a hospice care plan for this resident. Record review of Resident #15's "Transfer/Discharge Report" revealed the facility admitted the resident to the facility on 4/11/18. Record review of Resident #15's MDS Section O with Assessment Reference Date (ARD) of 8/12/24, revealed the resident was receiving hospice services. Section C revealed the Brief Interview for Mental Status (BIMS) should not be conducted due to "resident is rarely/never understood".	F 656	Improvement Monitor on 11/21/2024 to be monitored daily times 1 day beginning 11/21/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor to ensure that each resident receiving hospice services has a hospice care plan. Administrator added to facility Quality scorecard on 11/21/2024. The Quality Assurance Committee will review the monthly results beginning 12/19/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	
F 880 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	F 880		12/19/24

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F 880	Continued From page 7	F 880		

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 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

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F 880	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure the proper storage of a nebulizer facial mask and tubing to prevent contamination and the possibility of infection for one (1) of fourteen sampled residents. Resident #21. Findings Include: Record review of the facility policy titled "Oxygen/Nebulizer and Continuous Positive Airway Pressure (CPAP) Supplies" with a revision date of 03/13/18 revealed "...Place Oxygen/Nebulizer tubing/supplies and CPAP mask/supplies in plastic bag after each use...."	F 880	1. On 11/5/2024, nebulizer facial mask and tubing for Resident #21 was immediately discarded. On 11/5/2024, a new nebulizer facial mask and tubing were obtained for Resident #21. The facial mask and tubing were placed in a clean protective bag. On 11/5/2024, LPN#1 was verbally counseled by DON and Administrator of the requirement to keep nebulizer facial mask and tubing in protective covering when not in use. On 11/5/2024, Respiratory Therapist was verbally counseled by Administrator of the requirement to keep nebulizer facial mask	

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F 880	Continued From page 9 An observation on 11/04/24 at 10:40 AM, revealed a nebulizer machine on the nightstand next to Resident #21's bed and the facial mask and tubing were not in a plastic protective covering. An interview with Licensed Practical Nurse (LPN) #1 on 11/05/24 at 11:40 AM, confirmed that Resident #21's nebulizer mask and tubing were placed on top of the nightstand and were not inside a plastic protective bag. She revealed that a respiratory mask left open to air was an infection control issue, the mask could become contaminated with different germs and could cause respiratory infections. LPN #1 confirmed that the nebulizer facial mask and tubing should be in a protective covering when not in use. An observation and interview with the Administrator (ADM) on 11/05/24 at 11:45 AM revealed that nebulizer facial masks and tubing should be in a protective bag when not in use to prevent infection. She confirmed that Resident #21's nebulizer mask and tubing were placed on top of the nightstand and were not in a protective plastic bag. She revealed that leaving the nebulizer facial mask and tubing out and open to air could cause the spread of germs and respiratory infection. Record review of Resident #21's "Order Summary Report" revealed an order with a start date of 07/01/24 for "Albuterol Sulfate Solution Nebulizer 0.5% (5 milligrams per milliliter) 1 dose inhale orally via nebulizer every six hours as needed for coughing/wheezing." Record review of Resident #21's November	F 880	and tubing in protective covering when not in use. On 11/5/2024, Respiratory Therapy Department Manager was verbally counseled by Administrator of the requirement to keep nebulizer facial mask and tubing in protective covering when not in use. On 11/5/2024, Administrator and Director of Nursing went to all rooms where residents had nebulizers to ensure they were all in protective coverings. All nebulizer facial masks and tubing were in protective coverings. On 11/5/2024, Director of Nursing added order to Resident #21 orders to change and date storage bag weekly for nebulizer supplies. On 11/5/2024, Director of Nursing added order to all other residents with nebulizer treatments orders to change and date storage bag weekly for nebulizer supplies. 2. 3 residents have the potential to be affected by this deficient practice. 3. On 11/22/2024 and 11/26/2024, nurses were in-serviced by Administrator and Director of Nursing on ensuring that nebulizer facial masks and tubing are placed in a protective covering when not in use. On 11/22/2024, 11/23/2024, and 11/25/2024 Respiratory Therapy Department was in-serviced by Respiratory Therapy Department Manager on ensuring that nebulizer facial masks	

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F 880	Continued From page 10 "Respiratory Record" revealed that she received an albuterol breathing treatment by nebulizer on 11/04/24 at 8:23 AM and on 11/04/24 at 5:09 PM. Record review of Resident #21's "Admission Record" revealed an admission date of 08/21/20 and that she had diagnoses that included Shortness of Breath, Unspecified Dementia, and Chronic Obstructive Pulmonary Disease. Record review of Resident #21's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/05/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 06 which indicated that she had severe cognitive deficits.	F 880	and tubing are placed in a protective covering when not in use. 4. The Administrator developed a Quality Improvement Monitor on 11/22/2024 to be monitored daily times 1 day beginning 11/22/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that nebulizer facial masks and tubing are in protective coverings when not in use. Administrator added to facility Quality scorecard on 11/22/2024. The Quality Assurance Committee will review the monthly results beginning 12/19/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	