STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 re-certification survey with complaint investigations (CI), MS# 27587, CI MS#28336 and CI MS# 28360 at the facility from 3/30/25 through 4/2/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F 550, F 603, F 656, F 692, F 851, and F 880. The SA investigated CI MS # 27587, CI MS # 28336 and CI MS #28360 with no deficiencies cited. The census at the time of the survey was 99 and the facility is licensed for 105 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		4/29/25

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

Electronically Signed | 04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to ensure the dignity of one (1) of four (4) residents observed during medication administration. Resident #12. Findings Include: Review of the facility policy titled "Dignity and Respect" with a revision date of 7/2022 revealed, "5. Residents will be examined and treated in a manner that maintains bodily privacy. A closed door and/or drawn cubicle curtain should be utilized to maximize the privacy of each resident while rendering care." On 4/01/25 at 8:48 AM, an observation of	F 550	On April 2, 2025, Licensed Practical Nurse #1 was in-serviced by the Director of Nursing on Residents Rights to include providing dignity and privacy for Resident #12 by closing residents room door, blinds or pulling the privacy curtain prior to medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube. All residents receiving medication by way of a Percutaneous Endoscopic Gastrostomy (PEG) tube have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 550	Continued From page 2 Licensed Practical Nurse (LPN) #1 revealed, she administered Resident #12's, who was a female resident, Percutaneous Endoscopic Gastrostomy (PEG) tube medications without closing the resident's room door, blinds, or pulling the privacy curtain. The door of the resident's room remained open and anyone passing in the hallway could see that the resident's abdomen area was exposed. An interview with LPN #1 on 4/01/25 at 9:10 AM, confirmed she did not ensure the resident had privacy while administering medications through her PEG tube and revealed she should have provided privacy and maintained the dignity of the resident. During an interview with the Director of Nursing (DON) on 4/01/25 at 9:17 AM, she confirmed the nurse should have provided privacy for Resident #12 while administering medications through a PEG tube. Review of the "Admission Record" revealed that the facility admitted Resident #12 on 2/06/25, with a medical diagnosis that included Cerebral Infarction, Unspecified and Attention to Gastrostomy.	F 550	On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on providing privacy and maintaining dignity to residents during medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube. Licensed Practical Nurse #1 viewed and completed video titled All Staff Orientation to include Residents Rights on April 22, 2025. A Quality Assurance Meeting was held on April, 3, 2025, to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur. Beginning April 3, 2025, the Director of Nursing or Quality Improvement Nurse will observe medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube weekly for four weeks, then monthly for 3 months to ensure the residents dignity and privacy are being maintained. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns from medication administration observation in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from medication administration observations at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 550. The Quality Assurance Committee will revise the corrective action plan as needed until substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 550	Continued From page 3	F 550	compliance is achieved with F Tag 550.	
F 603 SS=G	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident/staff interviews, medical record review, and facility policy review, the facility failed to ensure a resident's right to be free from involuntary seclusion for one (1) of three (3) residents on transmission-based precautions (TBP). Resident #40 Findings include: Review of facility policy titled, "Incident Investigation & Reporting" dated 11/09/2009, reviewed 1/14/2025, revealed, "...Each resident residing in this facility has the right to be free from any type of abuse ...includes but is not limited to free from...involuntary seclusion...Involuntary Seclusion: Separation of a resident from other residents or from his/her room or confinement to his/her room..."	F 603	On April 1, 2025, the Administrator and Social Service Designee (SSD) informed Resident #40 that she was allowed to come out of her room, that she was not in isolation, and apologized to Resident #40 for the misunderstanding/miscommunication from staff that had been telling her otherwise. Resident #40 verbalized understanding of being allowed to come out of room. On April 1, 2025, the Activity Director visited with resident and discussed afternoon activities and going outside, however resident declined to participate in events. All residents who require Transmission Based Precautions (TBP) have the	4/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 4 Review of facility policy titled, "Policy for Control of Multidrug-Resistant Organism (MDRO) Infection" dated 6/14 reviewed 1/14/2025, revealed, "It is the policy of this facility to place residents in contact...precautions if they are displaying symptoms of active multidrug-resistant organism (MDRO) infection. Conditions requiring isolation include: ...If the resident has a draining wound that is infected with an MDRO, and the drainage cannot be contained..." Review of facility policy titled, "Resident's Rights Policy" dated 6/94, revised 12/23, reviewed 1/14/2025, revealed, "Every resident in this facility has the right to...Be free of...psychological...abuse..." During an observation and interview on 3/30/2025 at 3:53 PM with Resident #40 it was revealed that the resident had a red biohazard barrel in her room. The resident reported being in isolation, stating she was informed by numerous staff that she could not leave her room until 4/3/25 after her antibiotics were finished. During the interview the resident expressed frustration and stated, "I'm getting tired of it, I just want to go outside, I don't even care if it's raining." The resident acknowledged that isolation has increased her anxiety and depression, stating, "Just from staying in for that long, anyone would have it!" She emphasized, "I like to go outside and be in the air." A record review of Resident #40's "Order Summary Report" for the month of 3/2025, revealed an order, dated 3/13/2025, for Contact Isolation Precautions due to Methicillin Resistant Staphylococcus aureus (MRSA) of Wound.	F 603	potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 1, 2025, staff on duty was in-serviced by the Infection Preventionist on Hand Hygiene, Enhanced Barrier Precautions and Contact Precautions. On April 2, 2025, all staff was in-serviced by the Director of Nursing and Infection Preventionist on the Incident Investigation & Reporting Policy addressing Abuse, Neglect and Involuntary Seclusion and the Residents Rights Policy. On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on Abuse/Neglect, Involuntary Seclusion and Transmission Based Precautions (TBP). A Quality Assurance Meeting was held on April 3, 2025, to discuss findings from survey exit and any systematic changes needed to ensure deficient practice does not reoccur. Beginning April 3, 2025, any resident requiring Transmission Based Precautions (TBP) will be discussed in the Daily Stand-Up Meeting for the duration that the resident requires the TBP. Beginning April 3, 2025, the Social Service Designee (SSD) will visit all residents in Transmission Based Precautions (TBP) to assess for any psychosocial needs weekly for the duration of the Transmission Based Precautions and report any concerns to the Director of Nursing. Beginning April 3, 2025, the Director of Nursing or Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 5 A record review of a nursing "Progress Note," dated 3/13/2025 at 6:52 PM for Resident #40, revealed, "Dr (proper name) evaluated and reviewed labs...Doxycycline Monohydrate...related to MRSA infection...until 4/3/2025...contact isolation precautions due to MRSA of wound." Observation on 3/31/2025 at 9:00 AM, Resident #40 was observed to be in her room lying in bed. Record review of Resident #40's "Skilled Nursing Facility (SNF) Documentation Record" dated 3/13/2025 through 3/25/2025, revealed no more than a scant amount of drainage to scabbed areas with no drainage observed to the surgical site wound to her back during that timeframe. On 3/31/2025 at 1:20 PM, Resident #40 was observed to be in her room lying in bed. A record review of a psychotherapy "Progress Note" dated 3/12/2025 at 11:59 PM for Resident #40, revealed, "Reason for referral: 68 year old white female with follow up for insomnia, anxiety and depression...Resident's Statement: "I've had my surgery. I had a brown spot come out on the bandages and they sent it (a specimen) off" ...Case Conceptualization...Endorses good sleep...Says she is not depressed and does not feel anxious and thinks medications are working well. Good mood. Laughing and talking freely ..." A record review of Resident #40's psychotherapy "Progress Note" dated 3/20/2025 at 11:59 PM, revealed, "Diagnosis of Anxiety...Visit Summary...She shared she is frustrated as she is currently in isolation due to MRSA...She does	F 603	Preventionist will interview three staff members regarding the understanding of Transmission Based Precautions (TBP) with in-servicing provided as needed weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from Social Service Designee visits and staff interviews at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 603. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 603.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 6	F 603		

report frustration related to isolation. She stated it has made her feel more disoriented ..."

A record review of Resident #40's psychotherapy "Progress Note" dated 3/27/25 at 11:59 PM, revealed, "She has now been isolated to her room for two weeks due to MRSA. She stated she is managing but is ready to get out of her room...She has 7 more days. She reported some anxiety and depression due to isolation and shared that her daughter is not supportive of her leaving the facility."

During an interview on 4/1/2025 at 8:28 AM, with Certified Nursing Assistant (CNA) #3, she stated she was unsure of the type of isolation but confirmed that Resident #40 had not left her room in two (2) weeks. She confirmed that she has never seen any drainage on the residents' clothing or bed linen and stated there is always a small dressing covering the area.

During an interview on 4/1/2025 at 8:31 AM, with the Treatment Nurse, she stated Resident #40 had MRSA to her lower left back surgical incision and that the resident has been in isolation for a couple of weeks under contact precautions and is on a 21-day antibiotic regimen. She confirmed that the treatment order included covering the incision with a dressing, and any drainage from the wound has only been a scant amount and contained by the dressings. She also noted that the resident was alert, oriented, and capable of making decisions.

During an interview on 4/1/25 at 8:48 AM, with Infection Control (IC) Nurse, she confirmed the presence of MRSA in Resident #40's surgical incision. She confirmed that she was unaware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 7	F 603		

that the resident has been confined to her room, and stated, "Staff should have gotten her out of her room and allowed her to go out and get fresh air, maybe more staff education is warranted."

During an interview on 4/1/2025 at 8:59 AM, with the Activities Director and Activities #1, confirmed that Resident #40 and other staff informed her that the resident could not come out of her room for 21 days due to being in isolation. Activities #1 went on to reveal that Resident #40 does not attend a lot of activities but enjoys walking around and going outside of the building daily.

During an interview on 4/1/2025 at 9:11 AM, with Director of Nursing (DON) she stated, "Residents are not supposed to come out of their room if they are on contact precautions." She stated we cannot force any residents to stay in their room but encourage them to do so. She confirmed her certification in infection control but admitted she did not review Resident #40's isolation status or continued need for isolation, as it is a facility practice for residents on isolation to remain in their rooms until the medication is completed. She acknowledged concerns that isolation could lead to depression and feelings of confinement.

During an interview on 4/1/2025 at 9:16 AM, with the Social Services Director, she stated, "I didn't know Resident #40 was in isolation until just now, I would have increased my visits with her if I had known." She further reported that isolation could lead to increased anxiety and depression.

During an interview on 4/1/2025 at 9:33 AM, with Licensed Practical Nurse (LPN) #2, it was confirmed that Resident #40 was on contact isolation and must stay in her room to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 8	F 603		

contact with other surfaces or residents. She explained that residents placed in isolation are to remain on precautions until their antibiotic therapy is completed.

During an interview on 4/1/2025 at 9:37 AM, with Housekeeping Staff #1, she confirmed she had recently completed in-service training that stated that a resident should remain in their room if they are on contact isolation.

During a follow-up interview on 4/1/2025 at 9:40 AM, with the Infection Control Nurse, she acknowledged that the training was too broad, indicating that staff might interpret it to mean all residents on contact isolation should remain confined to their rooms. She said that she should have been more involved, but she had been teaching a CNA class for the past two (2) weeks, which limited her availability. She mentioned that had she been more present to review the infection log, she might have identified the situation sooner. She emphasized the need for treatment protocols for MDRO to be more personalized based on individual resident circumstances rather than applying a blanket policy of keeping residents in contact isolation until their medication regimen is completed. She confirmed that Resident #40 was alert, oriented, and able to follow directions. She noted that the residents' wound displayed only scant to zero drainage and remained covered. Furthermore, she stated that staff should have assisted the resident with hand hygiene and facilitated opportunities for her to go outside, acknowledging the importance of addressing the residents' emotional and mental well-being during isolation.

The Administrator was interviewed on 4/1/2025 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 9	F 603		

10:02 AM and confirmed that social isolation could lead to increased anxiety and depression among residents.

An interview with CNA #1 and CNA #2 on 4/1/2025 at 2:10 PM, both verbalized they were trained to ensure that residents on isolation remain in their rooms to prevent the spread of infection. They confirmed that they had never observed any drainage from Resident #40's back as the affected areas were consistently covered. Additionally, they noted that the resident often leaves her room to approach the nurse's medication carts and frequently goes to the doorway, and requires redirection back to her room.

During an interview with LPN #2 on 4/1/2025 at 2:20 PM, she also revealed that Resident #40 was alert, oriented and able to follow directions, additionally she confirmed the area to her back was always covered with a dressing and all drainage contained. She verbalized that the resident had never reported to her any increase in depression or anxiety, but stated she was not surprised as the resident has a history of both depression and anxiety.

An interview with Medicare Nurse on 4/2/2025 at 8:00 AM, revealed she is the case manager for Resident #40. She stated she was aware that the resident was on contact precautions but confirmed that the surgical wound was approximately 1 (one) CM (centimeter) in diameter and only presented with scant drainage at times, but most of the time the surgical site was scabbed over and was always covered with a bandage and any drainage would have been contained. She confirmed that the resident should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 10	F 603		

have been allowed to come out of her room for activities and socialization.

A phone interview with Social Services #1 for on 4/2/2025 at 8:10 AM, she revealed she is a psychiatric social worker and has Resident #40 on case load. She confirmed that Resident #40 has a history of anxiety and depression. She confirmed that she saw the resident on several occasions in March and the resident voiced her frustration of being in isolation and confirmed that the resident also spoke of her increased anxiety and depression due to the isolation. She confirmed she gives a visit recap to the nursing staff after every visit and documented her notes in the medical record.

An observation of Resident #40's surgical site on 4/2/2025 at 8:45 AM, with the DON revealed a secured dressing was removed, and revealed approximately a 0.1 CM open area noted with a scant amount of red drainage of the bandage. There was no drainage on the bed linens or the residents' clothing noted during this observation.

A record review of an "Admission Record" indicated the facility admitted Resident #40 on 11/29/22 with medical diagnoses that included Cerebral Infarction due to Thrombosis of Right Posterior Cerebral Artery, Encounter for Surgical Aftercare following Surgery on the Nervous System, Basal Cell Carcinoma of Skin of Other Part of Trunk, Anxiety Disorder, Depression, Mood disorder and MRSA Infection.

Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/3/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 603	Continued From page 11 13, which indicated the resident was cognitively intact.	F 603		
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 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	F 656		4/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 656	Continued From page 12 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to implement care plan interventions for a resident on a fluid restriction for one (1) of 24 care plans reviewed. Resident # 25. Findings Included: Record review of the facility policy "Care Plan Process" , revised 12/2024, revealed " The overall care plan should be oriented towards ...2. Managing risk factors to the extent possible ...Interventions are actions that should promote meeting the established goal." A record review of the "Care Plan Report" for Resident #25 revealed, under Focus, "Potential fluid volume overload related to Kidney failure." Under Interventions/Tasks it revealed "2,000-milliliter (ml) fluid restriction, with 120 ml allocated for four (4) medication passes, totaling 480 ml, and 500 ml with meals, totaling 1,500 ml", with a created date of 1/27/25. A record review of the electronic Medication Administration Record (MAR) for Resident #25	F 656	On April 1, 2025, the care plan intervention to document fluid intake, was added to the task list in the computer by the Medical Records Nurse for Resident #25. On April 1, 2025, the Medical Records Nurse was in-serviced by the Director of Nursing on ensuring all tasks pertaining to the residents plan of care and/or needs are initiated in the computer upon admission and as needed if residents condition changes. All residents that have a fluid restriction order have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 2, 2025, the nursing staff was in-serviced by the Director of Nursing on developing and implementing a care plan intervention for residents with a fluid restriction order. On April 9, 2025 all Licensed Nurses were in-serviced by the Director of Nursing on the Care Plan Process policy and implementing care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 656	Continued From page 13 revealed no documentation of the resident's fluid intake. On 4/1/25 at 1:00 PM, during an interview Licensed Practical Nurse (LPN) #3 confirmed that Resident #25 was on a 2,000 ml per day fluid restriction. She revealed that Certified Nursing Assistants (CNAs) document the amount the resident drinks during meals on the meal ticket and give it to the nurse, who then records the total fluid intake for the shift under the task list. Record review of the oral intake task list documentation with LPN #3 for Resident #24 revealed no documentation of oral intake for the past 30 days. On 4/1/25 at 1:10 PM, an interview LPN # 3 confirmed that there was no documentation of the resident's fluid intake, making it impossible to determine if the resident was adhering to the prescribed fluid restriction. She stated the importance of monitoring fluid intake to prevent fluid overload. Interview with Medicare Nurse #1 on 4/1/25 at 2:38 PM, she stated that the purpose of the care plan was to let staff know how to care for the resident. She stated that the staff failed to implement the care plan when they did not ensure the resident was following the fluid restriction, by documenting intake. She stated that not following the fluid restriction could cause fluid overload. A record review of the "Admission Record" revealed that the facility admitted Resident #25 on 1/27/25, with diagnoses including End-Stage Renal Disease and Congestive Heart Failure.	F 656	plan interventions based on a residents physician orders and/or needs. A Quality Assurance meeting was held on April, 3, 2025, to discuss findings from survey exit and systematic changes needed to ensure this deficient practice does not reoccur. Beginning April 3, 2025, in the Daily Stand-Up Meeting, Monday-Friday, the Director of Nursing or Medical Records Nurse will review the physicians orders to ensure all care plan intervention tasks are in place on the task list for accurate documentation. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns from the review of physicians orders/care plan intervention tasks in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from the review of physicians orders/care plan intervention tasks at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 656. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 656.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of three (3) residents reviewed for hydration. Resident #25. Findings Include: A record review of the facility policy "Physician Orders," revised 1/2025, revealed, "It is the policy of this facility that all physician's orders will be implemented timely and carried out in a professional manner."	F 692	On April 1, 2025, the task to document fluid intake was added to the task list in the computer by the Medical Records Nurse for Resident #25. On April 1, 2025, the Medical Records Nurse was in-serviced by the Director of Nursing on ensuring all tasks pertaining to the residents plan of care and/or needs are initiated in the computer upon admission and as needed if residents condition changes. All residents with a fluid restriction order have the potential to be affected by this	4/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 692	Continued From page 15 A record review of the facility policy "Fluid Restriction," revised 2/2022, revealed, "Fluids will be restricted for residents as directed by physician orders ... Nursing services will document intake and output." A record review of physician orders revealed that Resident #25 was placed on a 2,000-milliliter (ml) fluid restriction, with 120 ml allocated for four (4) medication passes, totaling 480 ml, and 500 ml with meals, totaling 1,500 ml. This order was initiated on 1/30/25. A record review of the electronic Medication Administration Record (MAR) for Resident #25 revealed no documentation of the resident's fluid intake. During an interview on 4/1/25, at 1:00 PM, Licensed Practical Nurse (LPN) #3 confirmed that Resident #25 was on a 2,000 ml per day fluid restriction. She explained that Certified Nursing Assistants (CNAs) document the amount the resident drinks during meals on the meal ticket and give it to the nurse, who then records the total fluid intake for the shift under the task list. A record review of the oral intake task list documentation, with LPN #3, for Resident #24 revealed no documentation of oral intake for over the past 30 days. During a further interview on 4/1/25 at 1:10 PM, LPN # 3 verified that there was no documentation of the resident's fluid intake, making it impossible to determine if the resident was adhering to the prescribed fluid restriction. She stated it was important to monitor fluid intake to prevent fluid overload.	F 692	deficient practice. No other residents were identified as being affected by this deficient practice. On April 2, 2025, the nursing staff was in-serviced by the Director of Nursing on documenting accurate intake for a resident with a fluid restriction order. On April 9, 2025 all Licensed Nurses were in-serviced by the Director of Nursing on the Fluid Restrictions policy and documenting intake every shift with a twenty-four hour total to ensure resident is compliant with fluid restriction order. A Quality Assurance Meeting was held on April, 3, 2025, to discuss findings from survey exit and systematic changes needed to ensure this deficient practice does not reoccur. Beginning April 3, 2025, the Medical Records Nurse or Director of nursing will audit all residents with a fluid restriction order daily (Monday-Friday) to ensure documentation for intake is complete. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns from the daily (Monday-Friday) audit for intake documentation in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from the review of physicians orders/care plan intervention tasks at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 692. The Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 692	Continued From page 16 During an interview with the Director of Nursing (DON) on 4/1/25 at 2:00 PM, she confirmed that Resident #25 had a fluid restriction ordered by the physician upon admission. She acknowledged that there was no documentation of fluid intake monitoring and confirmed that it should have been recorded. During an interview with the Medical Records Nurse on 4/1/25 at 3:00 PM, she confirmed that she was responsible for triggering documentation tasks upon admission. She admitted that she had failed to initiate a task for the nursing staff to document Resident #25's intake upon admission. A record review of the "Admission Record" showed that the facility admitted Resident #25 on 1/27/25, with diagnoses including End-Stage Renal Disease and Congestive Heart Failure.	F 692	Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 692.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851		4/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 851	Continued From page 17	F 851		

services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 851	Continued From page 18 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and Payroll-Based Journal (PBJ) staffing data review, the facility failed to submit PBJ data accurately to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed. 1st Quarter, 2025 (October 1 through December 31, 2024) Findings Include: An interview with the Administrator on 4/02/25 at 10:02 AM revealed the facility did not have a policy for submitting Payroll-Based Journal. Record review of the "Payroll-Based Journal (PBJ) Staffing Data Report" revealed the facility triggered for excessively low weekend staffing for the 1st quarter, 2025 (October 1 through December 31, 2024). An interview with the Staff Development Nurse on 4/01/25 at 10:10 AM revealed the facility's staffing needs were based on the minimum hours PPD (per patient day) requirement and by determining the resident acuity for each hall. She revealed call-ins were the biggest concern for weekend staffing. She indicated if a staff member clocked in late for their shift, that would affect the PPD. The Staff Development Nurse indicated they had an on-call nurse that took call from Friday until 7 AM on Monday. She revealed the on-call nurse was responsible for calling staff and trying to find a replacement for call-ins and, if not, she must	F 851	On April 2, 2025, the Director of Nursing was in-serviced by the Administrator on notifying the Administrative Assistant of any hours worked during any weekend shift (Saturday or Sunday) by Administrative staff that need to be manually transferred to direct care hours. All residents have the potential to be affected by this deficient practice. No residents were identified as being affected by this deficient practice. On April 3, 2025, the Administrative Assistant was in-serviced by the Administrator on the Labor Transfer Instructions Policy. On April 4, 2025, the Administrator and Administrative Assistant was in-serviced by the Regional Supervisor on Payroll Based Journal (PBJ) policies, procedures and data entry. A Quality Assurance Meeting was held on April 3, 2025, to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur. Beginning the week of April 7, 2025, and every week thereafter, the Administrator, Director of Nursing or Administrative Assistant will review the Pay Period Totals report for the prior weekend (Saturday and Sunday) to identify any hours worked	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 851	Continued From page 19 come in and work. An interview with the Administrative Assistant on 4/01/25 at 11:25 AM revealed she did the payroll for the facility, and their corporate office submitted the PBJ. A telephone interview with the Director of Special Projects on 4/01/25 at 11:39 AM revealed she worked with the corporate office and submitted the facility's PBJ. She indicated she had not received anything from CMS (Centers for Medicare and Medicaid Services), which indicated the facility had triggered for low weekend staffing. She revealed that the payroll data must be correct when it came over to her because she did not make any changes in the data. Furthermore, she confirmed her job duty was only to submit the data and indicated she did not go back into the system to check for any notifications or errors that might be reported from CMS and report back to the facility. An interview with the Administrative Assistant on 4/02/25 at 8:05 AM revealed when an administrative nurse came in to work on the weekend, she did not change their role in the payroll system to ensure the hours were captured under staff that provided direct care. She indicated those hours would have been included in the facility's PPD (patient per day) total but revealed if the role was not changed over to direct care staff, the PBJ information that was submitted to their corporate office would not be accurate. An interview with the Staff Development Nurse on 4/02/25 at 8:14 AM revealed that the administrative nurses who were on call were	F 851	by Administrative staff that need to be manually transferred to direct care hours. All PBJ staffing data will be reviewed by the 25th day of each month by the Administrator for alerts and errors prior to approving PBJ staffing data for submission. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from the Pay Period Totals review and PBJ data review at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 851. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 851.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 851	Continued From page 20 unable to clock in under regular nursing (direct care workers), and it had to be manually changed in the payroll system. An interview that included both the Regional Nursing Consultant and the Administrator on 4/02/25 at 10:04 AM revealed they did not have any dealings with PBJ and acknowledged this data should accurately reflect the facility's staffing. They confirmed the administrative staffing hours were not captured in the PBJ, which led to an inaccuracy with data submission.	F 851		
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 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;	F 880		4/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 880	Continued From page 21 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 880	Continued From page 22 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 interview, and facility policy review the facility failed to follow Enhanced Barrier Precautions (EBP) for one (1) of three (3) resident care observations. Resident #12. Findings Include: Review of the facility policy titled "Enhanced Barrier Precautions" with a revision date of 3/2024 revealed, "Enhanced Barrier Precautions are indicated for residents with any of the following: ... Wounds and/or indwelling medical devices ..." An observation outside Resident #12's room door on 4/1/25 at 8:42 AM, revealed a sign that read, "Enhanced Barrier Precautions." On 4/01/25 at 9:01 AM, an observation during medication administration with Licensed Practical Nurse (LPN) #1 revealed, she administered medications to Resident #12 via (by) Percutaneous Endoscopic Gastrostomy (PEG) tube without using a gown for EBP. An interview on 4/01/25 at 9:11 AM, with LPN #1, confirmed she did not apply a gown to administer Resident #12's medications. She explained that the gowns were not hanging on the resident's door; therefore, she did not realize she was supposed to wear one. LPN #1 indicated the purpose of wearing a gown was to reduce infection risk to the resident who had an indwelling device.	F 880	On April 2, 2025, Licensed Practical Nurse #1 was in-serviced by the Director of Nursing on the Enhanced Barrier Precautions (EBP) Policy. All residents that require Enhanced Barrier Precautions (EBP) have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 1, 2025, staff was in-serviced by the Infection Preventionist on Enhanced Barrier Precautions (EBP). On April 2, 2025, all staff was in-serviced by the Director of Nursing and Infection Preventionist on Infection Control and Enhanced Barrier Precautions (EBP). On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on Enhanced Barrier Precautions (EBP). A Quality Assurance Meeting was held on April 3, 2025 to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur. Beginning April 3, 2025, the Director of Nursing or Infection Preventionist will observe three residents that require Enhanced Barrier Precautions (EBP) to ensure staff is donning appropriate Personal Protective Equipment (PPE) prior to entering room weekly for four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 880	Continued From page 23 An interview with the Director of Nursing (DON) on 4/01/25 at 9:16 AM, confirmed LPN #1 should have worn a gown to administer medications to Resident #12 via PEG tube to protect the resident from infection. Record review of the "Admission Record" revealed the facility admitted Resident #12 on 2/06/25, with a medical diagnosis that included Cerebral Infarction and Attention to Gastrostomy.	F 880	weeks, then monthly for three months. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns regarding Enhanced Barrier Precautions (EBP) in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns regarding Enhanced Barrier Precautions (EBP) at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with F Tag 880. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 880.	