STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255227	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET , COLUMBIA, Mississippi, 39429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), MS #2594514 and MS #491498 at the facility from 09/08/2025 through 09/11/2025. CI MS #491498 was investigated for quality of care, and there were no citations related to this complaint. CI MS #2594514 was investigated for environment and air conditioning and there were no citations related to this complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F640, F656, F658, F677, F804, F880. The facility had a census of 90 and was licensed for 107 beds.	F0000		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System	F0640		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0640 SS = D	Continued from page 1 information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review, and interview, the facility failed to complete and submit a Minimum Data Set (MDS) discharge assessment in a timely manner in two (2) of (2) discharged residents reviewed. Findings include: On 09/11/2025 at 9:58 AM, during a record review and interview with Registered Nurse (RN) #2/ MDS nurse, it was revealed that Resident #98 was admitted on 04/03/2025 and discharged home on 06/14/2025. The discharge assessment with an Assessment Reference Date (ARD) of 06/14/2025, was submitted on and accepted on 07/09/2025, which is 25 days after the discharge date.	F0640		

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F0640 SS = D	Continued from page 2 On 09/11/2025 at 2:10PM, in an interview with the Administrator, the MDS discrepancy was discussed and the Administrator verbalized understanding of the importance of getting MDS records submitted on time. On 09/11/2025 at 2:24 PM, in an interview with the Director of Nursing (DON), the MDS discrepancy was discussed. The DON stated that she was aware of the discrepancy and saw where it could be a problem.Record review of the Resident Assessment Instrument (RAI) Manual, a discharge assessment must be completed within 14 calendar days after the resident's discharge and submitted no later than 14 days after completion. Record review of the MDS Coding Policy, reviewed 6/2/25 revealed that the facility utilizes the most up to date Resident Assessment (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.	F0640		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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F0656 SS = D	Continued from page 3 (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. §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 observations, interviews, record reviews and facility policy review the facility failed to follow the comprehensive care plan related to Percutaneous Endoscopic Gastrostomy (peg) tube medication for one (1) of (1) peg tube medication observations. Resident #16 Findings Include: A record review of the facility's "Care Plans, Comprehensive Person-Centered "last review date 1/2023, revealed "A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident…" A record review of Resident #16 comprehensive care plan created on 8/19/25 included interventions "Administer (proper name of each medication) as ordered." During an observation on 09/10/25 at 9:00 AM, during morning medication administration by Licensed Practical Nurse (LPN) #2 revealed LPN#2 crushed the medications and placed each medication separately in a dispense cup with 5 cubic centimeters (cc) water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral	F0656		

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F0656 SS = D	Continued from page 4 Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). LPN #2 administered the medications by peg tube but did not flush with water between the medications. After administering all medications, LPN#2 then flushed the peg tube with 30cc of water. In an interview on 09/10/25 at 9:59 AM, LPN #2 stated she thought she did something wrong but was not sure. She stated, “I usually flush between medications, but I am not sure.” In an interview on 09/10/25 at 2:20 PM, LPN #2 confirmed that she did not flush between medications as ordered by physician. She stated she forgot to flush between medications. She stated the reason for flushing is to make sure residents get all the medication and that by not flushing the peg tubing can become clogged. In an interview on 09/11/25 at 1:30 PM, with Registered Nurse (RN) #3)/ Assistant Director of Nursing (ADON) stated LPN #2 should have followed physician orders. She stated the purpose of flushing is to keep the tube patent. She stated she expects nurses to follow physician orders. In an interview on 09/11/25 at 1:38 PM, the Director of Nursing (DON) stated LPN #2 should have flushed the peg tube between medications. She stated the purpose is to make sure medications go down and make sure tube is patent. She stated the medication may not work effectively if physician orders are not followed. She stated she expects all staff to give medications correctly and way they have been trained. In an interview on 09/11/25 at 1:42 PM, Registered Nurse (RN) #2/Minimum Data set (MDS)/care plan nurse stated the purpose of the care plan is an outlook of what the residents care should be for all staff to follow. She confirmed LPN#2 did not follow the care plan. She stated she expects staff to follow the care plan. A record review of Resident #16 "Physician Orders" revealed crushed medications and placed each medication separately in a dispense cup with 5 cc water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban	F0656		

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F0656 SS = D	Continued from page 5 Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). Flush with 10 cc water of water between medications. A record review of Resident #16's "Admission Record" revealed an admission date of 1/30/25 with diagnoses that included Chronic Respiratory Failure with Hypoxia, Dyspnea unspecified, and Encounter for attention to Tracheostomy.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews and facility policy review the facility failed to administer medications by Percutaneous Endoscopic Gastrostomy (peg) tube according to physician orders for one (1) of four (4) medication observations. Resident #16. Findings Include: A record review of the facility's "Administrating Medication through an Enteral Tube" last reviewed date of 6/2025 revealed "…General Guidelines…3. Administer each medication separately and flush between medications…" On 09/10/25 at 9:00 AM, during an observation morning med administration by Licensed Practical Nurse (LPN) #2 revealed LPN#2 crushed the medications and placed each medication separately in a dispense cup with 5 cubic centimeters (cc) water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating	F0658		

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F0658 SS = D	Continued from page 6 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). LPN #2 administered the medications by peg tube but did not flush with water between the medications. After administering all medications, LPN#2 then flushed the peg tube with 30cc of water. On 09/10/25 at 9:59 AM, in an interview LPN #2 stated she thought she did something wrong but was not sure. She stated, “I usually flush between medications, but I am not sure.” On 09/10/25 at 2:20 PM, in an interview LPN #2 confirmed that she did not flush between medications as ordered by physician. She stated she forgot to flush between medications. She stated the reason for flushing is to make sure residents get all the medication and that by not flushing the peg tubing can become clogged. On 09/11/25 at 1:30 PM, in an interview with Registered Nurse (RN) #3)/ Assistant Director of Nursing (ADON) stated LPN #2 should have followed physician orders. She stated the purpose of flushing is to keep the tube patent. She stated she expects nurses to follow physician orders. On 09/11/25 at 1:38 PM, in an interview the Director of Nursing (DON) stated LPN #2 should have flushed the peg tube between medications. She stated the purpose is to make sure medications go down and make sure tube is patent. She stated the medication may not work effectively if physician orders are not followed. She stated she expects all staff to give medications correctly and way they have been trained. A record review of Resident #16 "Physician Orders" revealed orders for Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin),Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). Flush with 10 cc water of water between medications. A record review of Resident #16’s "Admission Record" revealed an admission date of 1/30/25 with diagnoses that included Chronic Respiratory Failure with Hypoxia, Dyspnea unspecified, and Encounter for attention to	F0658		

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F0658 SS = D	Continued from page 7 Tracheostomy. A record review of Resident #16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident was cognitively intact.	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide daily oral care for over three weeks for a resident who was totally dependent on staff for personal hygiene and oral care. This failure resulted in visible plaque buildup and placed the resident at risk for oral infection, discomfort, and diminished quality of life for one (1) of five (5) residents reviewed for activities of daily living (ADLs). Resident #43. Findings include: A record review of the facility policy "Activities of Daily Living (ADL) Supporting" revised 3/2018 revealed, "Policy Statement...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...." On 9/8/25 at 1:07 PM, during an observation and interview with Resident #43, he communicated that it had been over three weeks since his teeth had last been brushed. He communicated a desire to have his teeth brushed at least once per day and revealed that he required staff assistance to complete this task. Observation revealed significant plaque buildup on both his upper and lower teeth. On 9/9/25 at 8:59 AM, during a follow-up observation and interview with Resident #43, he communicated that his oral care had still not been provided. Observation revealed plaque remained visibly built up on both his upper and lower teeth. On 9/9/25 at 2:38 PM, an interview and in-room	F0677		

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F0677 SS = D	Continued from page 8 observation were conducted with the Registered Nurse (RN) Supervisor #1, who confirmed the resident's teeth appeared as though they had not been brushed in some time. She stated that oral care should be provided daily as part of the resident's assigned ADL care. On 9/9/25, at 2:41 PM, the RN Supervisor, State Agency (SA), and Certified Nursing Assistant (CNA) #1 entered the resident's room. CNA #1 acknowledged that she was assigned to Resident #43 on both the current and previous day. She admitted that she had not brushed the resident's teeth on either day and confirmed that daily oral care was required as part of her responsibilities, given the resident's inability to perform the task independently. During an interview with the Director of Nursing (DON) on 9/11/25 at 1:41 PM, she explained that oral care is a part of the daily ADL care that the CNAs perform and that she expects them to perform it as required. A record review of the Admission Record revealed the resident was admitted on 2/14/25 with diagnoses including Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side and Aphasia. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment. Section GG "Oral Care" indicated the resident was totally dependent on one staff member for all personal hygiene and oral care tasks.	F0677		
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy	F0804		

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F0804 SS = D	Continued from page 9 review the facility failed to ensure that food was palatable, attractive, and served at a safe and appetizing temperature for five (5) of (5) sampled food items. Specifically, the facility failed to ensure that meals were maintained at appropriate temperatures prior to service, which had the potential to affect the taste, safety, and nutritional value of meals served to residents. Findings include: A record review of the facility policy titled “Food: Quality and Palatability,” dated 2/2023, revealed "...Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature…Definitions…Proper (safe and appetizing) temperature. Food should be at the appropriate temperature as determined by the type of food to ensure resident’s satisfaction…” On 9/8/25 at 11:49 AM, temperatures of food items on the steam table were recorded as follows: chicken breast 109° Fahrenheit (F), pureed noodles 100°F, pureed peas 101°F, and pureed chicken 119°F. Only the chopped chicken reached a temperature of 148°F. On 9/8/25 at 12:01 PM, during an observation conducted with the Dietary Manager (DM), food items were observed being placed from the oven onto the steam table. The dietary staff then plated the food, placed onto carts, and served to residents in the dining hall at the temperatures documented as above. The DM acknowledged that steam table foods should reach and maintain at least 135°F to ensure proper holding temperature. She further confirmed that the kitchen’s window air conditioning unit blows directly over the steam table, contributing to premature cooling of the food items. Despite knowing this, she stated the facility had not implemented any corrective action or reliable protocol to maintain safe, warm, and appetizing food temperatures prior to meal service. On 9/9/25 at 7:47 AM, observation revealed the window air conditioning unit was again running and blowing directly onto the steam table. Temperature checks at that time revealed scrambled eggs at 108°F and pureed eggs at 100°F. The State Agency (SA) observed during this time food being plated, placed onto carts and being served to residents in the dining hall.	F0804		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = D	Continued from page 10 §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; §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	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255227	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET , COLUMBIA, Mississippi, 39429

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F0880 SS = D	Continued from page 11 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 observations, interviews, record reviews and facility policy review, the facility failed to administer medication in a manner to prevent infection for one (1) of four (4) medication administrations observed. Resident #99. Findings Include: A record review of the facility's "Infection Prevention and Control Program" with a revision date of 6/30/25 revealed "An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection..." On 09/10/25 at 8:25 AM, revealed Licensed Practical Nurse (LPN)#1 administered morning medication consisting of: Renvela Oral Tablet 800 milligrams (mg), Aspirin Enteric Coated (EC) Tablet Delayed Release 81 mg, B-Complex/Folic Acid/Vitamin C Oral Tablet Extended Release (B-Complex w/ C & Folic Acid),Clopidogrel Bisulfate Tablet 75 MG, Hydralazine HCl Oral Tablet 100 MG by mouth and Combigan Ophthalmic Solution 0.2-0.5 % (Brimonidine Tartrate-Timolol Maleate) one drop in each eye. LPN#1 gathered the medications and entered Resident #99's room. Resident #99 poured his medication on the overbed table and picked up one pill at time and	F0880		

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F0880 SS = D	Continued from page 12 placed it in his mouth. Resident #99's breakfast tray was still on the table and three pills rolled under his tray. LPN#1 moved the tray back and picked up the pills with her bare hands and placed them back on Resident #99's overbed table. Resident #99 continued to take the medications one at a time. LPN #1 sanitized her hands and applied gloves and administered Resident #99's eye drops. LPN#1 removed her gloves and the resident stated "You put the gloves on too late. You should have put them on before picking my pills up in your hands." On 09/10/25 at 8:45 AM, in an interview with LPN #1 she confirmed she was not supposed to pick up pills with her bare hands. She stated it is an infection control issue. A record review of Resident #99's "Order Summary Report" revealed physician orders for Renvela Oral Tablet 800 mg, Aspirin EC tablet delayed release 81 MG, B-Complex/Folic Acid/Vitamin C Oral Tablet Extended Release (B-Complex w/ C & Folic Acid),Clopidogrel Bisulfate Tablet 75 MG, Hydralazine HCl Oral Tablet 100 MG, all the above medications were by mouth and Combigan Ophthalmic Solution 0.2-0.5 % (Brimonidine Tartrate-Timolol Maleate) one drop each eye. A record review of Resident #99 "Admission Record" revealed an admission date of 9/5/25 with diagnoses that included Peripheral Vascular Disease, Unspecified Anemia, Chronic Kidney Disease, and Primary open-angle Glaucoma, bilateral severe stage. On 09/11/25 at 1:27 PM, in an interview Registered Nurse (RN) #3/ Infection Preventionist/Assistant Director of Nursing (IP/ADON) revealed LPN #1 should not have touched the medication with her bare hands. She should have let the resident pick them up by moving tray so the resident could get the medication. She stated that it is an infection control issue. On 09/11/25 at 1:35 PM, in an interview the Director of Nursing (DON) stated that LPN #1 should have washed her hands before picking up pills with her bare hands off the table. She stated that it is infection control issue.	F0880		