STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	**103 CUNNINGHAM DRIVE , RIPLEY, Mississippi, 38663**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with three (3) complaint investigations (CI), MS CI # 480894, MS CI # 2599038 and MS CI #2600438 at the facility from 9/2/25 through 9/4/25. 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 F584 for MS CI #2600438 related to Environment. There were no deficiencies cited for CI MS# 480894 or MS CI # 2599038. The SA also cited F604, F638, F640, F656, F677, and F880 for the annual certification. The census at the time of the survey was 53 and the facility is licensed for 60 beds.	F0000		
F0584 SS = E	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 services	F0584		

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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F0584 SS = E	Continued from page 1 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 interviews, record review and facility policy review, the facility failed to ensure the residents' environment was maintained in a homelike and sanitary manner as evidenced by the presence of a black substance in the grout lines of the shower stall wall tile, missing wall paint behind beds (Resident #17 and Resident #27) and torn bathroom flooring (Resident #4) for four (4) of 35 resident and facility rooms observed. The facility received F584 on the last annual survey therefore the scope and severity was raised to "E". Findings Include: Review of the facility policy titled “Shower and Tub Room Cleaning” revised 1/16 revealed under, “Procedure Description: This procedure will remove soap scum, dirt and debris from these areas providing a safe and sanitary place for the residents to bathe.” Also revealed under, “Procedure: … 2. Shower stall walls need to be cleaned daily using cloth and spray bottle of disinfectant solution. It may be necessary to use a scrub brush and diluted all purpose cleaner or tub/tile cleaner on walls monthly to remove residue from grout and corners.” Review of the facility policy titled "Homelike Environment" revised 5/22 revealed under, "Standard:	F0584		

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F0584 SS = E	Continued from page 2 Residents are provided a safe, clean, comfortable and homelike environment".On 9/2/25 at 10:23 AM, an observation of the shower room revealed that the lower shower wall tiles in the left stall were covered with a thick black substance along the grout lines and extended approximately five (5) to six (6) tiles up from the floor, reaching higher in the back two corners. The right shower wall tiles were the same and covered with a black substance in the crevices of the grout lines and extended approximately four (4) tiles up from the floor. Shower Room An observation of the shower stalls with Housekeeping Staff #2 on 9/2/25 at 10:28 AM confirmed the black substance in the grout lines of the tile. She stated, "It looks like mold," and revealed that a member of housekeeping was responsible for cleaning the showers and acknowledged that the condition was not a sanitary environment for residents. She confirmed that she cleaned the showers every evening at the end of the day with Clorox and water. She stated she did not have any products to clean the tile thoroughly to remove the buildup and stated, "It looked like that when I came here," and acknowledged she had not tried to clean the walls with a scrub brush to remove the buildup and the black substance. An observation and interview with the Administrator on 9/2/25 at 10:39 AM confirmed the showers should be cleaned thoroughly each day, including the walls, to remove any buildup and mold. He revealed that residents should have a clean, sanitary environment so infections do not spread. Resident #4 During an observation on 9/2/25, at 12:22 PM, it was noted that the linoleum flooring in Resident #4's bathroom had a torn area measuring approximately four (4) inches by five (5) inches, which exposed the concrete floor beneath. During an observation and interview on 9/4/25, at 8:55 AM, with the Maintenance Director and Director of Nursing (DON), both confirmed the presence of the torn area and acknowledged that it constituted a potential fall risk for residents, stating they were unaware of the damage prior to the observation. Record review of Resident #4's "Admission Record" revealed the resident was admitted to the facility on	F0584		

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F0584 SS = E	Continued from page 3 8/02/25, with a medical diagnosis that included Chronic Obstructive Pulmonary Disease (COPD). Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/25, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #4 is moderately cognitively impaired. Resident #17 During an observation on 9/2/25, at 1:48 PM, it was noted that there was a large area on the wall behind the headboard of Resident #17's bed that measured approximately three (3) feet by four (4) feet, exhibiting scratched and damaged paint. On 9/4/25, at 8:43 AM, an observation and interview with the Maintenance Director and DON, both individuals confirmed that the damaged area on the wall should have already been repainted, acknowledging that it detracts from the quality of the living environment for the resident. Record review of Resident #17 's "Admission Record" revealed the resident was admitted to the facility on 2/28/23, with a medical diagnosis that included Other Seizures. Record review of the MDS with an ARD of 8/13/25, revealed a BIMS score of 14, indicating Resident #17 is cognitively intact. Resident #27 During an observation on 9/2/25, at 12:22 PM, it was noted that there was a large area on the wall behind the headboard of Resident #27's bed that measured approximately three (3) feet by four (4) feet, exhibiting scratched and damaged paint. On 9/4/25, at 8:53 AM, an observation and interview with the Maintenance Director and DON, both individuals confirmed that the damaged area on the wall should have already been repainted, acknowledging that it detracts from the quality of the living environment for the resident. Record review of Resident #27 's "Admission Record" revealed the resident was admitted to the facility on 9/9/24, with a medical diagnosis that included Parkinson's Disease. Record review of the MDS with an ARD of 5/30/25,	F0584		

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F0584 SS = E	Continued from page 4 revealed a BIMS score of 14, indicating Resident #27 is cognitively intact.	F0584		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §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)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff and family interviews, record review, and facility policy review the facility failed to identify a bed rail as a physical restraint, failed to accurately assess the resident for the use of a bed rail, and failed to ensure that the bed rail did not pose a risk of injury from falls for one (1) of 18 sampled residents. Resident #35 Findings Include:	F0604		

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F0604 SS = D	Continued from page 5 Review of the facility policy titled “Physical Restraints” revealed under, “Physical Restraint Standards: The goal of this facility is to ensure that each resident attains and maintains his/her highest practical level of function and well-being in an environment that limits restraint use to circumstances in which the medical symptoms of the resident warrant the use of the least restrictive restraint...” An observation of Resident #35 on 9/2/25 at 2:45 PM revealed she was lying in bed with her eyes closed, and the bed was against the wall on her left side, with a full-length bed rail that was located on her right side, and a bed alarm was also in use. The resident was lying on a concave with raised edges mattress. Record review of Resident #35's "Bed Rail Use Screening Form" dated 6/23/25 revealed under, "Recommended Type Bedrail" 1/4 (one-quarter) length side rails were indicated.” An interview with the Assistant Director of Nursing (ADON) on 9/3/25 at 11:28 AM confirmed Resident #35's side rail assessment was not accurate. She explained that the resident had the full-length side rail already in place when she started working at the facility several months ago. The ADON stated the resident had the bed rail because a family member requested it to prevent the resident from falling. She revealed the resident tried to get out of the bed and sometimes scooted to the end of the bed trying to get up. Record review of Resident #35's "Bed Rails Informed Consent for Use" dated 5/3/24 revealed under, "Reason Bed Rail(s) Being Considered: Resident/Resident representative (RR) requested for safety.” Also revealed under, “Type of Rails: Right upper and lower.” An interview with the Director of Nursing (DON) on 9/3/25 at 3:48 PM revealed Resident #35's bed rail was applied because a family member was adamant about applying it due to frequent falls. She stated the family member signed the consent and understood the risk and that it could pose harm to the resident. An interview with a family member for Resident #35 on 9/4/25 at 10:36 AM revealed she knew the bed rail was a	F0604		

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F0604 SS = D	Continued from page 6 restraint and stated that was the purpose of the rail, to keep her mother in bed. She revealed a couple weeks ago the resident fell from the bed while trying to climb over the bed rail but was not hurt. Record review of Resident #35's "Fall with Injury Report" dated 8/13/2025 revealed under, "Incident Description: Resident was hollering out "Momma" this Nurse and CNA (certified nurse aide) headed to room, resident was falling to the floor." Also revealed under, "Immediate Action Taken: Head to toe assessment performed with abrasion noted to center of the back." An interview with the DON on 9/4/25 at 11:02 AM revealed Resident #35 did fall while trying to crawl over the bed rail and acknowledged the rail posed a greater risk for injures to the resident. She confirmed a restraint assessment was not done and acknowledged that positioning the bed against the wall, using a concave mattress along with a bed alarm and bed rail was restraining the resident from getting up easily. She confirmed this was done for family convenience related to falls rather than the safety of the resident and that the resident had not been screened properly for the restraints. Record review of the "Admission Record" revealed the facility admitted Resident #35 on 9/21/24 with a medical diagnosis of Chronic Diastolic (Congestive) Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #35 was severely cognitively impaired.	F0604		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility	F0638		

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F0638 SS = D	Continued from page 7 policy review, the facility failed to timely complete quarterly minimum data sets (MDS) within the time frame specified by Centers for Medicare and Medicaid Services (CMS) for three (3) of 21 minimum data sets reviewed. Resident #20, #41, #53 Findings Include: Review of the facility policy titled “MDS/RAI (Resident Assessment Instrument) Standard” unrevised, revealed under, “Standard: This facility makes a comprehensive assessment of each resident’s needs, strengths, goals, life history and preferences using the RAI specified by CMS.” Resident #20 Record review of Resident #20’s Quarterly MDS with an Assessment Reference Date (ARD) of 7/26/25 revealed under section Z0500, the assessment had not been completed. Record review of the "Admission Record" revealed the facility admitted Resident #20 on 7/10/25 with a medical diagnosis of hyperkalemia. Resident #41 Record review of Resident #41’s Quarterly MDS with an ARD of 8/2/25, revealed under section Z0500, the assessment had not been completed. Record review of the "Admission Record" revealed the facility admitted Resident #41 on 11/15/24, with a medical diagnosis of Disorder of Bone Density and Structure, Anemia, and Peripheral Vascular Disease. Resident #53 Record review of Resident #53’s Quarterly MDS with an ARD of 7/27/25 revealed under section Z0500, the assessment was not completed. Record review of the "Admission Record" revealed the facility admitted Resident #53 on 7/08/25 with medical diagnoses that included Severe Sepsis with Septic Shock. An interview with the MDS Nurse on 9/3/25 at 3:15 PM confirmed Resident #20, #41, and #53’s quarterly assessments were completed late. She explained that she had been out sick and fell behind in getting the assessment completed. The MDS Nurse stated the	F0638		

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F0638 SS = D	Continued from page 8 assessments should be closed and submitted timely to have accurate information on the residents and for payment purposes. An interview with the DON on 9/3/25 at 3:23 PM revealed her expectations were for the MDS assessment to be completed and submitted within the designated timeframe specified by CMS. She explained that she did not review the assessment to ensure they were completed timely.	F0638		
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 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.	F0640		

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F0640 SS = D	Continued from page 9 (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, staff interviews, and facility policy review, the facility failed to timely encode and transmit a discharge Minimum Data Set (MDS) as required by the Centers for Medicare and Medicaid Services (CMS) guidelines for one (1) of twenty-one (21) MDS reviewed. Resident #58. Findings Include: Review of the facility policy titled “MDS/RAI (Resident Assessment Instrument) Standard” unrevised, revealed under, “Standard: This facility makes a comprehensive assessment of each resident’s needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS.” Record review of Resident #58’s Discharge MDS with an Assessment Reference Data (ARD) of 6/6/25 revealed under section Z0500, an assessment completion date of 8/6/25, which indicated the assessment was completed late. Record review of the MDS “Final Validation Report” revealed Resident #58’s Discharge MDS was accepted by CMS on 8/20/25 with a warning message that read, “Assessment completed late: Z0500B (assessment completion date) is more than 14 days after A2300 ARD.” An interview with the MDS Nurse on 9/3/25 at 3:15 PM	F0640		

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F0640 SS = D	Continued from page 10 confirmed Resident #58's discharge assessment was completed late. She explained that she had been out sick and fell behind in getting the assessment completed. The MDS Nurse stated the assessments should be closed and submitted timely to have accurate information on the residents and for payment purposes. An interview with the Director of Nursing (DON) on 9/3/25 at 3:23 PM revealed her expectations were for the MDS assessment to be completed and submitted within the designated timeframe specified by CMS. She explained that she did not review the assessment to ensure they were completed timely. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 1/22/25 with medical diagnoses that included Anorexia and Repeated Falls.	F0640		
F0656 SS = E	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)-	F0656		

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F0656 SS = E	Continued from page 11 (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 observation, resident and staff interviews, record review, and facility policy review, the facility failed to develop the comprehensive care plan for one (1) of 18 sampled residents. (Resident #17) F656 was cited during the last annual survey, therefore the scope and severity was raised to "E". Findings include: Review of the facility policy titled, "Resident Centered Care Planning: Baseline Care Plan," dated 4/2025 outlines the standard: "The facility shall develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care…" Record review of Resident #17's "Activities of Daily Living (ADLs) Care Plan" date initiated 11/30/23 revealed, Interventions/Tasks did not include nail care. An observation and interview on 9/2/25 at 10:53 AM, with Resident # 17 revealed her fingernails were one-half inch in length, jagged, and had a brown substance underneath. Resident #17 expressed a desire to have her nails trimmed, stating she preferred them to be trimmed short. An interview on 9/3/25 at 11:09 AM, with Licensed Practical Nurse (LPN) #1 stated Resident #17's	F0656		

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F0656 SS = E	Continued from page 12 fingernails should have been trimmed by the nursing staff. She further verbalized the resident was at an increased risk for infection and skin tears due to having long, dirty jagged fingernails. An interview on 9/3/2025 at 11:35 AM, with the Minimum Data Set (MDS) Coordinator, she confirmed that the ADL care plan did not include nail care and was not fully developed. She verbalized that the care plan should have been developed to direct the care needed for the resident. Record review of the "Admission Record" indicated that the facility admitted Resident #17 on 2/28/2023, with a medical diagnosis that included Other Seizures. A record review of the MDS with an Assessment Reference Date (ARD) of 8/13/25, revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14 which indicated Resident #17 was cognitively intact.	F0656		
F0677 SS = E	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, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for one (1) of 18 sampled residents. (Resident #17) F677 was cited during the last annual survey, therefore the scope/severity was raised to "E". Findings include: Review of the facility policy titled, "Resident Hygiene: Care of Fingernails/Toenails," with a review date of 6/22 outlines the purpose of providing nail care: "To clean the nail bed, to keep nails trimmed and to prevent infections…" During an observation and interview on 9/2/25 at 10:53 AM, Resident # 17 revealed her fingernails were one-half inch in length, jagged, and had a brown substance underneath. Resident #17 expressed a desire to have her nails trimmed, stating she preferred them	F0677		

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F0677 SS = E	Continued from page 13 to be trimmed short. During an interview on 9/3/25 at 11:09 AM, Licensed Practical Nurse (LPN) #1 stated Resident #17's fingernails should have been trimmed by the nursing staff. She further verbalized the resident was at an increased risk for infection and skin tears due to having long, dirty jagged fingernails. During an interview on 9/3/2025 at 11:16 AM, with the Director of Nursing (DON), she confirmed that usually nailcare is performed during bath time by the Certified Nursing Assistants (CNAs) for non-diabetic residents. She acknowledged that long, dirty, jagged fingernails increased the risk of infections. The DON expressed her expectations that residents' nails should be kept clean and trimmed as necessary. Record review of the "Admission Record" indicated that the facility admitted Resident #17 on 2/28/2023, with a medical diagnosis that included Other Seizures. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/25, revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14 which indicated Resident #17 was cognitively intact.	F0677		
F0880 SS = E	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	F0880		

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F0880 SS = E	Continued from page 14 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 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.	F0880		

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F0880 SS = E	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review and staff interview, the facility failed to implement Enhanced Barrier Precautions (EBPs) as per Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for one (1) of one (1) resident (Resident #16) observed during Percutaneous Endoscopic Gastrostomy (PEG) medication administration. The nurse did not don appropriate personal protective equipment (PPE) before handling the PEG tube, creating the potential for cross-contamination and infection spread. F880 was cited during the last annual survey, therefore the scope and severity was raised to "E". Findings Include: Review of facility policy titled “Enhanced Barrier Precautions”, with a revision date of 5/2024, revealed, “Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).” On 9/3/25 at 9:10 AM, an observation of medication administration via (by) PEG tube with Resident #16, observed Licensed Practical Nurse (LPN) #1 not using Enhanced Barrier Precautions and the nurse did not wear a gown while administering medications to a resident at high risk for infections. An interview on 9/3/25, at 9:30 AM with LPN#1, she stated she forgot to wear her gown and that PPE was available and accessible to staff. She was able to verbalize that the purpose of wearing a gown would be to reduce infection risk when coming in and out of the resident’s room. An interview with the Director of Nursing (DON) on 9/3/25 at 11:00 AM, regarding EBP, stated that LPN#1 usually wears her gown and was probably nervous. She confirmed that she should have worn a gown to administer peg medications. She stated that the policy on EBP was in place and education was provided for staff and that an EBP sign was posted at resident’s door to remind the staff to wear PPE.	F0880		

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F0880 SS = E	Continued from page 16 Record review of the “Admission Record” revealed that the facility admitted Resident #16 on 8/07/25 with a medical diagnosis that included Pneumonia unspecified organism and Gastrostomy Status.	F0880		