STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK COMMUNITY CARE CENTER	**1900 CHADWICK DRIVE , JACKSON, Mississippi, 39204**

(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 at the facility from 01/27/25 through 01/29/26 During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F658, F677, F690, F757, F806, and F880. The facility had a census of 95 and was licensed for 102 beds.	F0000		
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		

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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F0656 SS = D	Continued from page 1 (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 observation, interviews, record reviews and facility policy review the facility failed to implement a comprehensive care plan related to Activities of Daily Living (ADL) and wound care for two (2) of six (6) care observations. Resident #60 and Resident #78. Findings Include: Record review of the facility policy “Comprehensive Person Centered,” revised 03/2022, revealed, “A comprehensive, person-centered care plan with measurable objectives and timetables to meet each resident’s physical, psychosocial, and functional needs is developed and implemented for each resident...” Resident #60 Record review of Resident #60’s “Care Plan Report” with a date initiated of 12/29/2025 revealed “…Approaches/Tasks: Cleanse site with wound cleanser, pat dry, apply skin preparation and barrier cream, and cover with a dry dressing daily and as needed...” On 01/28/2026 at 1:39 PM, an observation of wound care was conducted by Licensed Practical Nurse (LPN) #4. LPN#4 cleansed the wound with wound cleanser but did not pat dry prior to betadine application as ordered by the physician orders and the comprehensive care plan.	F0656		

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F0656 SS = D	Continued from page 2 On 01/28/2026 at 3:05 PM, during an interview, LPN #4 stated he was not aware he failed to pat the wound dry. He stated patting the wound dry creates a dry barrier that supports wound healing. He stated he did not follow the care plan. On 01/29/2026 at 3:10 PM, during an interview, the Director of Nursing (DON) stated staff are expected to follow the comprehensive care plan because it informs staff of the care required. She stated she expects staff to follow the care plan. Record review of Resident #60's "Admission Record" revealed an admission date of 09/29/2025 with diagnoses that included Type 2 Diabetes Mellitus without complications and Hypertensive Heart Disease without Heart Failure. Record review of Resident #60's "Order Summary Report" with active orders as of 1/29/26 revealed a physician order dated 1/9/26 for intact blister to the left heel to be cleansed with wound cleanser, patted dry, betadine applied daily, and covered with a dry dressing as needed. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident is cognitively intact. Resident #78 Record review of the "Care Plan Report "with a revision date of 6/18/25 revealed "Problem…has potential for ADL self-care deficit related to she requires staff for assistance…Approaches… Dressing, grooming, personal hygiene x 1 person assistance…Oral hygiene-substantial to maximal assistance x 1…" On 01/27/2026 at 11:54 AM, during an interview, Resident #78 stated things were going okay at the facility. She stated she wants her teeth brushed daily but cannot remember the last time staff brushed them because she requires staff assistance. She stated staff do not often cut her nails and the nails on her contracted hand are long and digging into her skin. She stated she would like them trimmed. She also stated she dislikes the hair under her chin and requests staff keep it trimmed regularly. On 01/28/2026 at 5:36 PM, during an interview, the Registered Nurse (RN) and MDS nurse stated the purpose of the care plan is to provide a plan of care for staff	F0656		

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F0656 SS = D	Continued from page 3 to follow and for families to understand the care being provided. She stated nurses and Certified Nursing Assistants (CNAs) are expected to follow the care plan and if they do not, they are not following the established plan of care. She stated all staff should be following it. Record review of Resident #78's Admission Record revealed an admission date of 01/15/2021 with diagnoses including unspecified osteoarthritis, unspecified site. Record review of the MDS with an ARD of 11/25/2025 revealed a BIMS score of 15, indicating the resident is cognitively intact.	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 observation, interview, record review, and facility policy review, the facility failed to follow standards of practice during medication administration and wound care for two (2) of five (5) residents observed for medication administration and wound care. Residents #8 and #60. Findings Include: Record review of the facility policy "Wound Care", revised 1/9/22, revealed "The purpose of the procedure is to provide guidelines for the care of wounds to promote healing..." Record review of the facility policy "Administering Medications through an Enteral Tube", undated, revealed, "General Guidelines… Administer each medication separately and flush between medications..." Resident #8 On 01/28/2026 at 8:30 AM, Licensed Practical Nurse (LPN) #1 was observed administering medications to Resident #8 via percutaneous endoscopic gastrostomy tube. During medication administration, the nurse administered multiple medications through the tube	F0658		

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F0658 SS = D	Continued from page 4 without flushing with water between each medication. The tube became clogged, requiring the nurse to use a syringe plunger to push the medications after gravity flow stopped. On 01/28/2026 at 9:51 AM, during an interview, LPN #1 confirmed she did not flush the feeding tube with water between each medication. She confirmed the physician order required a 15-milliliter (ml) flush between each medication. She stated complications of not following the order could include tube clogging, difficulty with medication administration, and possible need for emergency room transfer to clear or replace the tube. On 01/28/2026 at 11:49 AM, during an interview, the Director of Nursing (DON) stated the feeding tube should have been flushed with 15 ml of water between each medication to prevent clogging. She stated nurses are expected to follow physician orders. Record review of Resident #8's "Admission Record" revealed an admission date of 08/15/2023 with a diagnoses that included peritoneal abscess. Record review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/2025 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment. Record review of Resident #8's "Order Summary Report" with active orders as of 1/28/26 revealed a physician order to flush the feeding tube with 60 cubic centimeters (cc's) of water before and after medication administration, flush with 15 cc's between medications, and dilute medications with 5 cc's of free water. Resident #60 On 01/28/2026 at 1:39 PM, an observation of wound care was conducted by LPN #4. LPN#4 cleansed the wound with wound cleanser but did not pat dry prior to betadine application as ordered by the physician orders. On 01/28/2026 at 3:05 PM, during an interview, LPN #4 stated he was not aware he failed to pat the wound dry. He stated patting the wound dry creates a dry barrier that supports wound healing. On 01/29/2026 at 3:10 PM, during an interview, the DON stated LPN #4 should follow physician orders when performing wound care. She stated the wound should have been patted dry prior to betadine application. She stated the purpose of patting the wound dry is to	F0658		

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F0658 SS = D	Continued from page 5 remove excessive moisture. She stated excessive moisture can delay healing and cause maceration. Record review of Resident #60's "Admission Record" revealed an admission date of 09/29/2025 with diagnoses that included Type 2 Diabetes Mellitus without complications and Hypertensive Heart Disease without Heart Failure. Record review of Resident #60's "Order Summary Report" with active orders as of 1/29/26 revealed a physician order dated 1/9/26 for intact blister to the left heel to be cleansed with wound cleanser, patted dry, betadine applied daily, and covered with a dry dressing as needed. Record review of the MDS with an ARD of 12/29/2025 revealed a BIMS score of 13 indicating the resident is cognitively intact.	F0658		
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 observations, interviews, record review and facility policy review, the facility failed to consistently provide necessary activities of daily living (ADL) care, including daily oral hygiene, routine nail care, and regular shaving of facial hair for one (1) of (19) residents reviewed. Resident #78. Findings include: Record review of the facility policy, "Activities of Daily Living (ADL's) Supporting" revised March 2018, revealed, "…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 1/27/26 at 11:51 AM, during an interview with Certified Nursing Assistant (CNA) #1, he stated that he had been assigned to provide ADL care to Resident #78 for the past two days. He explained that oral care and grooming, such as shaving, are routine parts of ADL care. He acknowledged that he had failed to perform this type of ADL care for Resident #78 but stated he	F0677		

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F0677 SS = E	Continued from page 6 could do it now if the State Agency (SA) would like him to. On 1/27/2026 at 11:54 AM, during an interview with Resident #78, she stated that things are going “okay” at the facility. She reported that she wants her teeth brushed daily but cannot remember the last time staff brushed them because she needs their help to do so. She added that staff do not often cut her nails, and the nails on her contracted hand are long and digging into her skin and she would like them trimmed. She also mentioned that she dislikes the hair under her chin and requests that the staff keep it trimmed regularly. Observation of Resident #78’s nails revealed they were long and digging into the skin of her contracted hand, leaving a deep impression. The resident’s facial chin hair was long, gray, and curled to the point of resembling a beard. There was an extremely large amount of plaque buildup on her teeth, indicating they had not been brushed in quite some time. On 1/27/26 at 12:04 PM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that the hair under Resident #78’s chin had not been shaved in quite some time. She stated that the CNA’s role is to ensure it is cut as needed. During the assessment of Resident #78’s nails on her contracted left hand, LPN #1 confirmed to the SA that the nails were long, leaving a deep indentation in her skin, and could cause further injury if not cut. She also acknowledged that Resident #78’s teeth had extensive plaque buildup and needed to be brushed. On 1/28/26 at 11:45 AM, during an interview with the Director of Nursing (DON), she stated that CNAs are required to perform oral care and facial grooming, such as removing facial hair, but that nurses are responsible for cutting residents’ nails. In an interview with CNA #2 on 1/28/26 at 2:36 PM, she stated that removing facial hair and providing oral care are routine parts of ADL care. She explained that she removes facial hair to help residents feel more confident, and that oral care is important to prevent cavities and bad breath. Record review of the "Admission record" revealed the facility admitted the resident on 1/15/21 with diagnoses including unspecified osteoarthritis, unspecified site. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/25 revealed a	F0677		

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F0677 SS = E	Continued from page 7 Brief Interview Mental Score (BIMS) of (15) indicating the resident is cognitively intact.	F0677		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure an indwelling urinary catheter was secured with a leg strap for one (1) of four (4) residents reviewed with urinary catheters. Resident #2. Findings Include: Record review of the facility policy “Catheter Care,	F0690		

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F0690 SS = D	Continued from page 8 Urinary", undated, revealed "…Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site..." On 01/29/2026 at 10:53 AM, during an observation and interview of foley catheter care conducted by Certified Nursing Assistant (CNA) #3, assisted by CNA #4 revealed upon removal of Resident #2's pajamas a leg strap to secure the catheter was not in place. CNA #3 and CNA #4 confirmed there was not a leg strap in place to secure the catheter. CNA #4 stated Resident #2 should have a leg strap. She stated the purpose is to prevent the catheter from pulling out. She stated she notifies the nurse when one is not present. On 01/29/2026 at 2:56 PM, during an interview, the Director of Nursing (DON) stated CNAs should apply a leg strap during care and do not need to notify a nurse to do so. She stated the purpose of the leg strap is to keep the catheter in a stationary position to prevent dislodgement or injury. She stated staff are expected to follow the plan of care and apply the leg strap. Record review of Resident #2's "Admission Record" revealed an admission date of 02/05/2025 with diagnoses that included Neuromuscular Dysfunction of the Bladder. Record review of the "Order Summary Report" with active orders as of 1/29/26 revealed physician orders dated 11/17/25 for catheter care with soap and water each shift and as needed, and to observe for placement of a catheter leg strap with tubing secured each shift. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2026 revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.	F0690		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F0757		

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F0757 SS = D	Continued from page 9 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were clinically indicated and free from unnecessary use for one (1) of seven (7) sampled residents reviewed for unnecessary medications. Resident #5. Findings Include: Record review of Resident #5's medication orders revealed an active order for Narcan Nasal Liquid 4 milligrams per 0.1 milliliters, spray alternating nostrils every two minutes as needed for signs and symptoms of overdose including unresponsiveness, shallow breathing, and cyanosis, with instructions to notify the Medical Doctor and Emergency Medical Services immediately. (Narcan is indicated to reverse the effects of opioid overdose.) Record review of Resident #5's medication orders revealed an active order for Narcan Nasal Liquid 4 milligrams per 0.1 milliliters, spray alternating nostrils every two minutes as needed for signs and symptoms of overdose including unresponsiveness, shallow breathing, and cyanosis, with instructions to notify the Medical Doctor and Emergency Medical Services immediately. Record review of the "Order Summary Report" revealed Resident #5 did not have any opioids ordered. The only sedative medication ordered was Clonazepam 0.5 milligrams, give 0.25 milligrams by mouth every 12 hours related to anxiety disorder. While Clonazepam may cause sedation, unresponsiveness, or respiratory depression, these effects are not reversed by Narcan,	F0757		

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F0757 SS = D	Continued from page 10 rendering the order clinically unnecessary and non-beneficial to the resident. On 01/29/2026 at 12:15 PM, during an interview, the Director of Nursing confirmed Resident #5 did not have any opioids ordered. She stated she needed to review the pharmacologic action of Narcan to determine if it would reverse the effects of Clonazepam. After reviewing the medication orders and drug action, she confirmed Narcan would not benefit the resident if unresponsiveness occurred from Clonazepam use. She stated the order was likely selected in error when a nurse submitted a batch of orders to the provider for signature. She stated the order did not apply to the resident and was selected by mistake. She further acknowledged that if she had to research the drug action, it would be difficult to expect nursing staff to appropriately select medications without error. Record review of Resident #5's "Admission Record" revealed an admission date of 11/09/2015 with a diagnoses that included paroxysmal atrial fibrillation. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/06/2026 revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment.	F0757		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide alternative menu choices and ensure meal preference options were communicated for one (1) of (19) sampled residents reviewed for food service choices. Resident #70.	F0806		

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(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
F0806 SS = D	Continued from page 11 Findings Include: On 01/27/2026 at 12:32 PM, during an interview, Resident #70 stated he sometimes does not like the food he is served. He stated he did not know alternate meals were available. He stated when he tells the Certified Nursing Assistants (CNAs) he does not like the meal served, sometimes they bring something else and other times they do not. He stated he is not aware of what foods are being served daily and would like to know what is being served. On 01/28/2026 at 11:06 AM, during an interview, Resident #70 stated he still did not know what foods would be served that day. Observation of the resident's room revealed there was not a menu posted in the room. On 01/28/2026 at 11:23 AM, during an interview, the Dietary Manager stated menus are posted on each hall. She stated CNAs ask residents at lunch and notify kitchen staff of resident choices. She stated culinary meetings are held on Fridays with approximately 35 residents attending. She stated the weekly menu is reviewed at that time and residents may voice concerns. She confirmed that all residents do not attend the meetings. On 01/28/2026 at 3:00 PM, during an interview, CNA #3 stated she was assigned to Resident #70. She stated she passes breakfast and lunch trays. She stated if residents do not want the meal served, she goes to the kitchen to ask about alternatives. She stated she does not know alternate meals until residents refuse the tray. She stated she does not inform residents of alternative lunch or dinner options in advance because she does not know them until she asks dietary staff. She stated residents are not told of the alternatives unless they refuse the meal after trays are served. On 01/29/2026 at 3:16 PM, during an interview, the Director of Nursing stated menus are posted near the dining room and on meal carts so staff can inform residents of alternative meals. She stated it is important that residents are given choices and informed prior to mealtimes so they can participate in care decisions. She stated her expectation is for CNAs to inform residents of meal options before trays are served. Record review of Resident #70's "Admission Record" revealed an admission date of 07/18/2022 with diagnoses that included of Hypertensive Heart Disease without Heart Failure and Hyperlipidemia.	F0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

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F0806 SS = D	Continued from page 12 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.	F0806		
F0880 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; §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	F0880		

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F0880 SS = D	Continued from page 13 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow infection prevention and control guidelines during medication administration for one (1) of four (4) residents reviewed for medication administration. Resident #8. Findings Include: Record review of the facility policy, revised October 2018, revealed “This facility's infection control policies and practices are intended to… help prevent and manage transmission of disease and infection. On 01/28/2026 at 8:30 AM, medication administration was observed for Resident #8 via percutaneous endoscopic gastrostomy tube. Prior to administration, Licensed Practical Nurse (LPN) #1 removed the stopcock plunger from the feeding tube syringe and placed it on top of the plastic container it came in. During medication	F0880		

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F0880 SS = D	Continued from page 14 administration, the stopcock plunger slid off the plastic container onto the bare bedside table, which had not been disinfected prior to medication preparation. During the medication administration process, the resident's feeding tube became clogged, requiring LPN#1 to use the stopcock plunger to push the medication through the tube. LPN#1 did not disinfect the stopcock plunger after it contacted the bedside table. The plunger was placed directly back into the syringe and used to administer medication into the resident's feeding tube. On 01/28/2026 at 9:51 AM, during an interview, LPN#1 confirmed the stopcock plunger had been resting on the bedside table prior to use. She stated proper infection prevention practice would have required disinfecting the bedside table prior to medication administration or discarding the contaminated syringe and stopcock and obtaining a new one. She stated failure to follow infection prevention guidelines could result in transmission of infection to the resident. On 01/28/2026 at 11:49 AM, during an interview, the Director of Nursing (DON) stated LPN#1 should have disinfected the bedside table prior to medication administration and used a clean barrier before placing equipment on the surface. She stated once the syringe plunger contacted the table, the nurse should have obtained a new syringe or disinfected the equipment prior to use. She stated potential complications of this practice include transmission of infection to the resident. She stated it is her expectation that nurses follow infection prevention guidelines during medication administration. Record review of Resident #8's Admission Record revealed an admission date of 08/15/2023 with a diagnoses that included peritoneal abscess. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/2025 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment.	F0880		