STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255316	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE , 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 at the facility from 2/9/26 through 2/12/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F583, F604, F658, F756, F801, F812, and F880. The facility had a census of 81 and was licensed for 86 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to dignity, as evidenced by standing over the resident while assisting to feed for one (1) of (18) sampled residents. Resident #34. Findings include: A review of the facility's "Dignity Policy," undated, revealed, "…Dignity means that staff carry out activities which assist the resident to maintain and enhance his/her self-esteem and self-worth as follows…Promoting resident independence and dignity in dining…" A record review of Resident #34's "Face Sheet" revealed the facility admitted Resident #34 on 7/16/12 with diagnoses including Hemiplegia and Hemiparesis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident's cognition was severely impaired. On 2/9/26 at 11:54 AM, during an observation, Certified Nursing Aide (CNA) #1 was observed assisting Resident #34 with feeding in the resident's room. She was standing over the resident during lunch. CNA #1 tilted her arm downward to place food into the resident's mouth. Two vacant chairs were present in the resident's room, and three chairs were located in the hallway adjacent to the resident's door. On 2/9/26 at 12:05 PM, during an interview, CNA #1 acknowledged she assisted Resident #34 with feeding while standing over the resident. She reported she was aware she was expected to feed residents while seated	F0550		

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F0550 SS = D	Continued from page 2 at eye level. She reported she was aware two chairs were available in the room, and three chairs were located in the hallway near the resident's door. She reported she did not sit because she had been told the chairs were for family members and affirmed no family members were present during the meal. On 2/11/26 at 11:29 AM, during an interview, the Director of Nursing (DON) reported the importance of sitting during feeding assistance was to improve positioning and reduce the likelihood of aspiration. She reported her expectation was for staff to sit when assisting residents with feeding. On 2/12/26 at 10:40 AM, during an interview, the Administrator reported standing over a resident during feeding was a dignity concern and disrespectful and stated his expectation was for staff to sit during assisted feedings.	F0550		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at	F0583		

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F0583 SS = D	Continued from page 3 §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to privacy and confidentiality by posting personal care information in the resident's room for one (1) of two (2) residents sampled for privacy. Resident #8. Findings include: A review of the facility's "Privacy of Health Information Policy," undated, revealed, "… It is the policy of this facility that resident's health information will be protected as follows: … No health information allowed on counter tops or in areas visible to unauthorized persons … - Posting notes and reminders in the residents' rooms by staff members will be prohibited (unless resident and/or responsible party has given us permission to do so AND it has been added to the resident's care plan) …" A record review of Resident #8's "Face Sheet" revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Encounter for Attention to Gastrostomy. A record review of the "Order Summary Report" with active orders as of 2/10/26 revealed Resident #8 had physician orders for "… All Oral Meds to Be Given Via percutaneous endoscopic gastrostomy (Peg) Tube as Previously Ordered (dated 1/2/26) … NPO (nothing by mouth) Status (dated 1/7/26) … Diet: Nutren 2.0 at 30 ml (milliliters) per hour continuous via PEG tube (dated 12/15/25) … Keep Head of Bed Elevated 30 Degrees or Greater at All Times R/T (related to) Peg Tube and Risk of Aspiration (dated 12/15/25) …" On 2/11/26 at 9:31 AM, during an observation and interview, Licensed Practical Nurse (LPN) #3 was observed administering medications via PEG tube to Resident #8. Two (2) signs were observed posted on the wall above the resident's headboard indicating to "Keep Head of Bed elevated at 30-45 degrees to prevent aspiration" and "Nutren 2.0 at 30 ml/hr (milliliters/hour) continuous via PEG tube" and "All	F0583		

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F0583 SS = D	Continued from page 4 meds given via PEG tube." LPN #3 confirmed the signs and reported the information reflected private health information contained in the resident's medical record and care plan. On 2/11/26 at 10:19 AM, during an interview, the Director of Nursing (DON) confirmed signage containing resident personal care information should not be posted in resident rooms. She reported Resident #8 recently received a new PEG tube due to decreased appetite and weight loss. She confirmed the information posted above the resident's headboard included personal care information and should not have been posted due to privacy concerns. She reported the information was available in the resident's medical record for staff access. She reported she was not aware the signs were posted and did not know who posted them or how long they had been posted. She stated her expectation was for staff to honor resident privacy and not post personal care information unless requested by the family. On 2/12/26 at 1:27 PM, during an interview, the Administrator reported he expected staff to honor resident privacy and not post personal care information in resident rooms.	F0583		
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.	F0604		

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F0604 SS = D	Continued from page 5 §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, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by failing to identify and document the use of a lap belt as a restraint for one (1) of eighteen (18) sampled residents. Resident #55. Findings include: A review of the facility's "Restraint Policy," undated, revealed, "…Physical restraints are defined as any manual method or physical mechanical device, material, or equipment attached…to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body…" On 2/9/26 at 3:55 PM, during an observation, Resident #55 was observed with a soft belt secured across her lap while up in a wheelchair. On 2/10/26 at 11:46 AM, during an observation, Licensed Practical Nurse (LPN) #1 asked Resident #55 three (3) times to remove the belt. Resident #55 stared at the nurse and did not respond to the request. On 2/11/26 at 11:32 AM, during an interview, the Director of Nursing (DON) reported the facility failed to identify the resident's lap belt as a restraint. She reported the importance of properly identifying the belt as a restraint as a way to ensure staff were aware of required monitoring, including releasing it every thirty (30) minutes and checking for proper fit. She reported that the Quality Assurance (QA) nurse was responsible for ensuring restraints were identified properly and stated she would ensure proper assessment for restraint use and reduction. On 2/11/26 at 11:36 AM, during an interview, LPN #2, QA nurse, reported he did not identify Resident #55's lap belt as a restraint. He reported he was under the	F0604		

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F0604 SS = D	Continued from page 6 impression the resident could remove the belt and stated he would ensure residents were properly assessed for restraint use in the future. On 2/12/26 at 10:42 AM, during an interview, the Administrator reported Resident #55's lap belt should have been identified as a restraint. He reported the resident had previously been able to remove the belt, but her cognition had declined and she should have been evaluated more frequently. He reported his expectation was for the lap belt to be properly identified and monitored for continued need. A record review of Resident #55's "Face Sheet" revealed the facility admitted Resident #55 on 2/26/24 with diagnoses including Unspecified Dementia. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/21/26 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident's cognition was severely impaired. A record review of Resident #55's medical record revealed there was no documentation identifying the use of a lap belt as a restraint.	F0604		
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 state board of nursing information review the facility failed to follow professional standards by permitting an unlicensed Certified Nursing Aide (CNA) to apply a medicated product, zinc oxide, during incontinent care for one (1) of three (3) residents observed for care. Resident #10. Findings include: A review of the Mississippi Board of Nursing website (www.msbn.ms.gov) revealed, "Can a RN (Registered Nurse) delegate the administration of medicated ointments, lotions, and protective skin barriers to	F0658		

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F0658 SS = D	Continued from page 7 unlicensed personnel?...The registered nurse may …2. Assign duties of administration of patient medications to other licensed nurses only…" On 2/11/26 at 12:35 PM, during an observation, CNA #2 provided catheter and incontinent care to Resident #10 and applied zinc oxide to the perineal folds. A record review of the "Order Summary Report" for Resident #10 revealed a Physician's Order, dated 2/2/26, for "Zinc Oxide skin protection…CNA may apply per nurses' direction for skin protection only… On 2/11/26 at 12:45 PM, during an interview, Resident #10 reported staff routinely applied zinc oxide after catheter and incontinent care. On 2/11/26 at 12:50 PM, during an interview, CNA #2 reported she was instructed by the Director of Nursing (DON) to apply zinc oxide after incontinent episodes to prevent skin breakdown. On 2/12/26 at 2:00 PM, during an interview, the DON reported she instructed CNAs to apply zinc oxide to incontinent residents for skin protection and stated she was unaware zinc oxide was considered a medicated product. On 2/12/26 at 2:12 PM, during an interview, the Administrator reported he was unaware zinc oxide was considered a medicated product and stated he was seeking a non-medicated barrier cream alternative. A record review of the "Face Sheet" revealed the facility admitted Resident #10 on 11/25/25 with diagnoses including Heart Failure. A record review of Resident #10's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/26 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.	F0658		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F0756		

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F0756 SS = D	Continued from page 8 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to act upon a pharmacist-identified medication irregularity related to crushing an extended-release medication for one (1) of three (3) residents reviewed for medication administration. Resident #8. Findings include: A review of the facility's "Pharmacy Consultant Policy," undated, revealed, "… It is the policy of this facility that a licensed pharmacist will provide consultation … A monthly report of any irregularities found is made to the resident's physician (placed on the medical record) The Director of Nursing (DON) …	F0756		

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F0756 SS = D	Continued from page 9 Action taken based on the report will be documented … A file of monthly reports will be maintained by the Director of Nursing …" A record review of the "Pharmacy Recommendations for Nursing" for Resident #8, dated 11/12/25 revealed, "… Medication Administration Alert: Crushing of Meds. This resident's record indicates that their meds are (or can be) crushed. The following meds SHOULD NOT be crushed, (change to another form of therapy): … Toprol XL (metoprolol succinate ER) – Extended Release – can not be crushed or chewed …" A record review of the "Order Summary Report" with active orders as of 2/10/26 revealed Resident #8 had a Physician's Order, dated 12/15/25 for "Toprol XL Oral Tablet Extended Release 24 Hour 50 mg (milligram) (Metoprolol Succinate) Give 1 tablet via PEG-Tube one time a day for Hypertension…" A record review of Resident #8's "Medication Administration Record (MAR)" for November 2025 revealed Toprol XL Extended Release 50 mg was administered by mouth daily (start date 2/8/24). A record review of the December 2025 MAR revealed Toprol XL Extended Release 50 mg was administered daily via percutaneous endoscopic gastrostomy (PEG) tube beginning 12/16/25. A record review of the January and February 2026 MARs revealed the medication continued to be administered daily via PEG-Tube through 2/12/26. On 2/11/26 at 9:31 AM, during an observation and interview, Licensed Practical Nurse (LPN) #3 was observed preparing and administering medications to Resident #8 via PEG tube. LPN #3 crushed Toprol XL Extended Release 50 mg and administered the medication via PEG tube. LPN #3 reported she was not aware the medication should not be crushed. On 2/11/26 at 2:22 PM, during a phone interview, the Pharmacy Consultant reported Toprol XL Extended Release should not be crushed and explained crushing could result in altered absorption, decreased effectiveness, and release of the full dose at one time, increasing potential side effects. She reported she issued a nursing consult on 11/12/25 identifying medications that should not be crushed for Resident #8 and explained recommendations are sent to the Director of Nursing (DON) for follow-up and correction. On 2/11/26 at 3:00 PM, during an interview, the DON reported when pharmacist recommendations include medications that should not be crushed, she typically posts a list of medications that cannot be crushed but	F0756		

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F0756 SS = D	Continued from page 10 did not ensure the medication was changed to an appropriate formulation for PEG administration. She reported Resident #8 received the PEG tube in 12/2025 and medications should have been converted to an appropriate form. On 2/12/26 at 12:30 PM, during a follow-up interview, the DON reported it was her responsibility to follow through on pharmacist recommendations and ensure timely completion. She reported the recommendation for Resident #8 was missed and confirmed several months was not a timely response. On 2/12/26 at 12:59 PM, during an interview, the Nurse Practitioner reported Toprol XL Extended Release should not be crushed due to its extended-release formulation. She reported the medication should have been changed to an appropriate formulation after PEG placement and stated the issue was missed. On 2/12/26 at 1:27 PM, during an interview, the Administrator reported nursing staff were expected to follow through timely on pharmacist recommendations and correct identified irregularities. A record review of the “Face Sheet” revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Essential (Primary) Hypertension and Encounter for Attention to Gastrostomy. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #8 required a Staff Assessment for Mental Status indicating memory problems with short- and long-term memory. Section K revealed the resident had a feeding tube.	F0756		
F0802 SS = D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff.	F0802		

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F0802 SS = D	Continued from page 11 The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff demonstrated competency in sanitation procedures for the three-compartment sink for one (1) of three (3) kitchen observations. Findings include: A review of the facility's "Manual Warewashing Policy," dated 10/17 revealed, "…Food service pots and pans that cannot fit in the dish machine or cleaned and sanitized in a three-compartment sink…Procedure…5) Third Compartment Sink a) Fill the third sink with water and sanitizer to the correct concentration. Hot water can be used as an alternative. B) Immerse items in the third sink in hot water or chemical sanitizing solution. I)If hot water immersion is used, the water must be a minimum of 171°F and items must be immersed for 30 seconds. Ii) If chemical sanitizing is used, the sanitizer must be mixed to the proper concentration. Follow manufacturers' recommendations. The following are published guidelines. (1) Chlorine—Immerse for 7 seconds in water temperature 100 degrees F (Fahrenheit) (2) Iodine—Immerse for 30 seconds in water temperature 68 degrees F. (3) Quats—Immerse for 30 seconds in water temperature 75 degrees F. (6) The concentration of the sanitizing solution is checked with an appropriate test kit when the sink is filled and again if the solution is used for an extended period of time…" On 2/10/26 at 10:48 AM, during an observation and interview, Dietary Aide (DA) #2 washed pots and pans in the three-compartment sink. Pots and pans were observed air drying on a table next to the sink. The third sink contained warm water, and a test strip did not register sanitizer concentration. DA #2 aide added sanitizing solution directly from the container into the sink without measuring the amount. After adding the solution, the test strip registered between 200 and 400 parts per million (PPM). DA #2 confirmed the sanitation equipment was not working and she added sanitizer based on estimation. During an interview at this time, the Dietary Manager (DM) stated she had washed pots and	F0802		

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F0802 SS = D	Continued from page 12 pans earlier using what she believed was correct sanitation and confirmed the sanitation tubing had been disconnected. The DM stated she did not know who disconnected the solution tubing. On 2/11/26 at 11:51 AM, during an interview, the Maintenance Director stated she contacted the sanitation vendor after being notified the sanitation equipment was not working. On 2/11/26 at 12:06 PM, during an interview, the Sanitation Vendor Representative stated the sanitation equipment was functioning properly and explained sanitizer should not be manually poured into sinks, as the equipment is designed to dispense the correct concentration, confirming staff were not utilizing the equipment as designed. On 2/12/26 at 11:28 AM, during an interview, the Administrator stated staff are expected to use sanitation equipment according to manufacturer guidelines.	F0802		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812		

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F0812 SS = F	Continued from page 13 Based on observation, interview, record review, and facility policy review, the facility failed to sanitize pots and pans according to manufacturer's guidelines and failed to calibrate food thermometers to ensure food remained hot for one (1) of four (4) kitchen observations. Findings include: A review of the facility's "Calibration of Thermometers Policy," revised 10/17, revealed, "…Facility shall ensure that a thermometer gives accurate recordings. Procedure: 1. All thermometers are to be calibrated: a. Before each use b. After being dropped c. When experiencing an extreme change in temperature…" A review of the facility's "Manual Warewashing Policy," dated 10/17 revealed, "…Food service pots and pans that cannot fit in the dish machine or cleaned and sanitized in a three-compartment sink…Procedure…5) Third Compartment Sink a) Fill the third sink with water and sanitizer to the correct concentration. Hot water can be used as an alternative. B) Immerse items in the third sink in hot water or chemical sanitizing solution. I)If hot water immersion is used, the water must be a minimum of 171°F and items must be immersed for 30 seconds. Ii) If chemical sanitizing is used, the sanitizer must be mixed to the proper concentration. Follow manufacturers' recommendations. The following are published guidelines. (1) Chlorine—Immerse for 7 seconds in water temperature 100 degrees F (Fahrenheit) (2) Iodine—Immerse for 30 seconds in water temperature 68 degrees F. (3) Quats—Immerse for 30 seconds in water temperature 75 degrees F. (6) The concentration of the sanitizing solution is checked with an appropriate test kit when the sink is filled and again if the solution is used for an extended period of time…" On 2/10/26 at 10:35 AM, during an observation, the Dietary Manager (DM) checked food temperatures on the steam table using a manual thermometer and failed to calibrate the thermometer prior to testing the food. On 2/10/26 at 10:48 AM, during an observation and interview, Dietary Aide (DA) #2 washed pots and pans in the three-compartment sink. Pots and pans were observed air drying on a table next to the sink. The third sink contained warm water, and a test strip did not register sanitizer concentration. DA #2 stated the sanitation equipment was not working. The sanitation container was observed to be under the sink without the sanitation tubing connected.	F0812		

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F0812 SS = F	Continued from page 14 On 2/10/26 at 10:48 AM, during an interview, the DM confirmed she failed to calibrate the thermometer because it had been calibrated previously by another cook and confirmed thermometers were not calibrated before each meal. The DM also confirmed the sanitation tubing had been disconnected from the three-compartment sink and was later reconnected to allow sanitizer to dispense into the sink. On 2/10/26 at 11:54 AM, during a follow up interview, DA #2 explained that while washing the pots and pans in the three-compartment sink, she did not initially add sanitizing solution to the sink and believed sanitizer may have already been present from earlier use. On 2/12/26 at 11:28 AM, during an interview, the Administrator stated staff are expected to calibrate thermometers and use sanitation equipment according to manufacturer guidelines.	F0812		
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	F0880		

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F0880 SS = D	Continued from page 15 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow Enhanced Barrier Precaution (EBP) requirements by not wearing required personal protective equipment (PPE), specifically a gown, during percutaneous endoscopic	F0880		

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F0880 SS = D	Continued from page 16 gastrostomy (PEG) tube care for one (1) of five (5) residents observed for care. Resident #8. Findings include: A review of the facility's "Enhanced Barrier Precautions Policy," dated 4/30/25, revealed, "…Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms to residents...Policy Interpretation and Implementation EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply…Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include…device care or use…feeding tube…Communication -Staff are trained prior to caring for residents on EBP and annually with PPE (Personal Protective Equipment) in-service…An orange sign will be placed on the resident door frame and a green dot on the name tag next to the door indicating the need for EBP…" On 2/11/26 at 10:14 AM, an observation of Resident #8's, Enhanced Barrier Precaution signage, including an orange sign and green dot, was observed on the resident's door. During the same observation, Licensed Practical Nurse (LPN) #4 performed PEG tube dressing care and did not wear a gown while providing the care. On 2/12/26 at 1:00 PM, during an interview with LPN #4, she confirmed she did not wear a gown during PEG tube care for Resident #8 and stated she forgot to put it on. She reported she had been trained to wear personal protective equipment (PPE) when providing care to residents with medical devices and Enhanced Barrier Precaution signage. On 2/12/26 at 1:03 PM, during an interview with Registered Nurse (RN) #1/Infection Preventionist, she stated staff are trained to wear PPE when caring for residents identified with Enhanced Barrier Precaution signage and medical devices. On 2/12/26 at 1:04 PM, during an interview with the Director of Nursing (DON), she stated she expects staff to follow Enhanced Barrier Precaution policies to prevent infection transmission. On 2/12/26 at 1:05 PM, during an interview with the Administrator, he stated he expects staff to follow infection control and Enhanced Barrier Precaution policies when providing resident care.	F0880		

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F0880 SS = D	Continued from page 17 A record review of training documentation from "Long-Term Care Consultant, LLC," dated 8/03/25, revealed Licensed Practical Nurse (LPN) #4 received training on Enhanced Barrier Precautions. A record review of the "Face Sheet" revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Essential (Primary) Hypertension and Encounter for Attention to Gastrostomy. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #8 required a Staff Assessment for Mental Status indicating memory problems with short- and long-term memory. Section K revealed the resident had a feeding tube. A record review of the "Order Summary Report" with active orders as of 2/10/26 revealed Resident #8 had a Physician's Order, dated 12/15/25 for NPO (nothing by mouth) status and included PEG care orders.	F0880		