STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPPAH COUNTY NURSING HOME	1005 CITY AVENUE NORTH PO BOX 499, 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 recertification survey at the facility from 2/17/26 through 2/19/26. During the survey, the SA determined that the facility was not in compliance with the Medicare and Medicaid regulations for participation and cited regulatory deficiencies F565, F584, F656, F677, F761, F801, and F880. The facility had a census of 32 and was licensed for 40 beds.	F0000		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F0565		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

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F0565 SS = D	Continued from page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on staff and family interview, facility policy review and record review, the facility failed to act on and resolve grievances related to maintaining Activity of Daily Living (ADL) needs for incontinent residents for one (1) of three (3) family interviews conducted. Resident #27 Findings Include: Review of the facility policy titled "Activities of Daily Living (ADL) Care," dated 04/09/2018, stated, "To ensure all ADL care is provided on a daily basis as needed to ensure that all the residents' needs are met. On each shift all residents are checked every two hours, and adult brief is changed if needed." An interview conducted via telephone with Resident #27's caregiver on 2/18/26 at 8:53 AM, revealed the caregiver reported Resident #27 had been left in a soiled brief on more than one occasion while she was visiting daily. The caregiver stated staff informed her that residents were not to be changed during meals times and meal tray passes. The caregiver expressed concern that her mother remained in a soiled brief for several hours hour until meal service was completed. Review of Resident Council meeting minutes dated 9/09/25, revealed administration instructed staff not to provide incontinence care during mealtimes. During interviews conducted on 2/18/26 at 10:32 AM with Certified Nursing Assistants (CNA) #1 and CNA #2 confirmed staff were expected to complete tray pass and feeding residents before providing incontinence care during meal service. On 2/18/26 at 10:40 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that incontinence care is not to be completed during mealtimes. During an interview on 2/19/26 at 11:00 AM, the Administrator stated the expectation was for staff to provide incontinence care every two hours and as needed, including during mealtimes. The Administrator stated residents should not remain in soiled briefs and that she would make sure to address the grievance and work to resolve it and was unaware that it was still an ongoing problem. Review of the Admission Record	F0565		

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F0565 SS = D	Continued from page 2 indicated Resident #27 was admitted to the facility on 6/01/25 with medical diagnoses that included Cerebral Infarction. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/25, revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 07, indicating Resident #27 has severely impaired cognition.	F0565		
F0584 SS = D	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 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;	F0584		

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F0584 SS = D	Continued from page 3 §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 interview, and facility policy review, the facility failed to maintain a safe, clean, and homelike environment by ensuring window coverings were intact and in good repair for two (2) of the twenty-nine resident rooms observed. (Room #230 and #232). Findings Include: Record review of the facility policy titled, "Homelike Environment" dated 11/21/2024, revealed, "Residents are provided with a safe, clean, comfortable, and homelike environment. ..." During the initial tour on 2/17/26 between 10:37 AM and 10:43 AM, observation revealed the window blinds in rooms 230 and room 232 had broken and missing slats, leaving an approximate 30-inch gap at the bottom and exposing the outside elements. On 2/18/26 at 10:50 AM, Certified Nurse Aide (CNA) #1 stated that when disrepair is noted in a resident room, nursing staff are notified so maintenance can be contacted. CNA #1 confirmed she observed the window blinds in room 230 with multiple broken and missing slats and reported the issue that morning. She further confirmed the blinds in room 232 were broken with missing slats, exposing the room to outside elements. On 2/18/26 at 11:10 AM, the Administrator confirmed the window blinds in rooms 230 and 232 were broken, looked unsightly, and did not meet the facility's expectation of providing a homelike environment. On 2/18/26 at 1:30 PM, the Maintenance Director stated that maintenance needs are addressed when a work order is submitted. He reported he was notified that morning about replacing the blinds in room 230 and confirmed they were broken with missing slats. He stated he had not been made aware of the need to inspect or repair the blinds in room 232.	F0584		
F0656 SS = D	Develop/Implement Comprehensive Care Plan	F0656		

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F0656 SS = D	Continued from page 4 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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.	F0656		

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F0656 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to implement comprehensive care plans for one (1) of 13 sampled residents. (Resident #2) Findings include: Review of the facility policy titled "Minimum Data Set (MDS) 3.0; Care Plans" with review date 6/23/2016, revealed, "...The services provided or arranged by the facility must meet professional standards of quality; and be provided by qualified persons in accordance with each resident's written plan of care..." Resident #2 Record review of Care Plan for Diabetes Mellitus, initiated 8/26/2024, revealed, "...Diabetic nail care on Tuesdays..." Record review of Activities of Daily Living (ADL) Care Plan, initiated 8/26/2024, revealed, "...Personal Hygiene...The resident is able to perform care with cueing and supervision..." On 2/17/2026 at 10:32 AM, during observation and interview Resident #2 was observed to have noticeably long, jagged fingernails measuring approximately one (1) inch in length and a few scattered long facial hairs on her chin, approximately one and one-half inches in length. The resident stated her nails were too long and needed to be trimmed and that she did not want facial hair and would like that to be trimmed. On 2/18/2026 at 9:45 AM,during an interview and observation Licensed Practical Nurse (LPN) #1 confirmed Resident #2 had long, jagged fingernails that could cause the resident to sustain a skin tear. She stated that because Resident #2 has diabetes, a Registered Nurse (RN) is required to trim the resident's nails. She further stated diabetic nail care is scheduled on the Treatment Administration Record (TAR) every Tuesday to be completed by the Registered Nurse (RN). Additionally, she confirmed that Resident #2 did have several long chin hairs. She stated that the shower aide should have taken care of this when she got her shower. During an interview on 2/19/2026 at 10:11 AM, the Minimum Data Set (MDS) Nurse confirmed the ADL and Diabetes Mellitus care plans were not implemented. She	F0656		

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F0656 SS = D	Continued from page 6 stated the purpose of the care plans were to give guidance for individualized care for each resident. Record review of the Admission Record indicated Resident #2 was admitted to the facility on 2/8/2024 with medical diagnoses that included Encephalopathy, unspecified and Type Two (2) Diabetes Mellitus without complications. Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/13/25, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #2 was cognitively intact.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, 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 13 sampled residents. (Resident #2). Findings include: Review of facility policy titled "Activities of Daily Living (ADL) Care, revised 4/9/2018, revealed, "Purpose: To ensure all ADL care is provided on a daily basis as needed to ensure that all the residents' needs are met...Policy:..6. Nail care is provided every week and as needed to all residents with the exception of diabetics. Only the Registered Nurse (RN) can perform diabetic nail care..." Resident #2 During observation and interview on 2/17/2026 at 10:32 AM, Resident #2 was observed to have noticeably long, jagged fingernails measuring approximately one (1) inch in length and a few scattered long facial hairs on her chin, approximately one and one-half inches in length. The resident stated her nails were too long and needed to be trimmed and that she did not want facial hair and would like for that to be trimmed as well.	F0677		

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F0677 SS = D	Continued from page 7 During an interview and observation on 2/18/2026 at 9:45 AM, Licensed Practical Nurse (LPN) #1 confirmed Resident #2 had long, jagged fingernails that could cause the resident to sustain a skin tear. She stated that because Resident #2 has diabetes, a Registered Nurse (RN) is required to trim the resident's nails. She further stated diabetic nail care is scheduled on the Treatment Administration Record (TAR) every Tuesday to be completed by the RN. Additionally, she confirmed that Resident #2 did have several long chin hairs. She stated that the shower aide should have taken care of this when she got her shower. Record review of the TAR dated 2/1/2026-2/28/2026, revealed, "...Diabetic Nail Care on Tuesday every day shift every Tuesday TO BE COMPLETED BY RN..." During an interview on 2/18/2026 at 9:50 AM, the Administrator stated diabetic nail care was scheduled for Tuesdays to be completed by the Registered Nurse and that it should have been completed the previous day. She confirmed the resident could sustain a skin tear if she scratched herself with the overgrown nails. She further stated that female residents should not have unwanted facial hair. She further stated that the shower aide should have trimmed those while she had her in the shower. Record review of the Admission Record indicated Resident #2 was admitted to the facility on 2/8/2024 with medical diagnoses that included Encephalopathy, unspecified and Type Two (2) Diabetes Mellitus without complications. Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/13/25, revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #2 was cognitively intact.	F0677		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F0761		

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F0761 SS = D	Continued from page 8 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to ensure medications were accurately labeled and corresponded with the physician's order for one (1) of three (3) residents observed during medication pass (Resident #38) Findings Include: Review of facility policy titled, “Medication Administration” with revision date 6/7/2016, revealed, “…Procedures…5. If there is a discrepancy between the Emar and the label, check physician/NP (nurse practitioner) orders before administering the medication. 6. If label is wrong, call resident’s personal pharmacy for a new label. If the Emar is wrong, correct the order in the computer system…” An observation during medication administration on 2/18/2026 at 8:55 AM revealed Licensed Practical Nurse (LPN) #1 retrieved a pharmacy-prepared blister pack labeled Gabapentin Oral Tablet 300 milligrams (mg) from the locked narcotic box in the medication cart and punched out two (2) tablets. She stated the order on the Medication Administration Record (MAR) read, "Gabapentin Oral Tablet 600 mg. Give one (1) tablet by mouth two times a day for Pain" so I have to give two (2) tablets to equal the 600 mg dosage. Record review of the MAR confirmed the order was for Gabapentin 600 mg tablet, give one (1) tablet. During this observation, the LPN retrieved another pharmacy-prepared blister pack labeled Propranolol HCl ER Oral Capsule Extended Release 24-hour 80 mg and	F0761		

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F0761 SS = D	Continued from page 9 punched out two (2) capsules. Again, she stated that the order on the MAR read, "Propranolol HCl ER Oral Capsule Extended Release 24-hour 160 mg. Give one (1) capsule by mouth two times a day for Hypertension. Record review of the MAR confirmed the order was for Propranolol HCl ER Oral Capsule Extended Release 24-hour 160 mg, give one (1) capsule." The LPN stated that these two blister packs have been labeled like this since admission. The LPN administered the medications along with other morning medications to Resident #38. Medication Administration Record (MAR) did not match the Gabapentin Oral Tablet 300 mg tablets or the Propranolol HCl ER Oral Capsule Extended Release 24-hour 80 mg on hand in the blister packs, revealing a discrepancy between the physician's order and the labeled medication for Resident #38. Record review of Resident #38's "Medication Administration Record (MAR)" revealed an order dated 2/9/2026 for "Gabapentin Oral Tablet 600 mg. Give one (1) tablet by mouth two times a day for Pain" and an order dated 2/9/2026 for "Propranolol HCl ER Oral Capsule Extended Release 24-hour 160 mg. Give one (1) capsule by mouth two times a day for Hypertension." Review of Resident #38's pharmacy-prepared blister pack of Gabapentin 300 mg tablets revealed, "Gabapentin Oral Tablet 300 mg. Give two (2) tablets by mouth two (2) times a day for Pain." Review of Resident #38's pharmacy-prepared blister pack revealed "Propranolol HCl ER Oral Capsule Extended Release 24-hour 80 mg. Give two (2) capsules by mouth two times a day for Hypertension." During an interview on 2/18/26 at 9:00 AM, LPN #1 confirmed Resident #38's physician order and medication label did not match. She stated the discrepancy had been present since admission on 2/9/2026 and stated, "I've never thought to get it changed." During an interview on 2/19/2026 at 9:00 AM with the Administrator and Director of Nursing (DON), the Administrator and DON revealed they were unaware of the discrepancy and that nursing staff should have reported so it could have been corrected. The DON stated this could cause a medication error when the blister pack medication strength does not match what is ordered on the MAR. Record review of Resident #38's "Admission Record" revealed the facility admitted the resident on 2/9/2026 with diagnoses including Disorder of muscle, unspecified, Pain, unspecified, and Essential Primary	F0761		

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F0761 SS = D	Continued from page 10 Hypertension. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/16/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13 which indicated Resident #38 was cognitively intact.	F0761		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §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. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F0801		

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TIPPAH COUNTY NURSING HOME	1005 CITY AVENUE NORTH PO BOX 499, 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
F0801 SS = F	Continued from page 11 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on review of personnel records and staff interviews, the facility failed to ensure that the Dietary Manager was qualified by obtaining or enrolling in a Certified Dietary Manager (CDM) program for three (3) of 3 days of survey. Review of facility policies related to dietary staff	F0801		

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F0801 SS = F	Continued from page 12 qualifications was requested. Facility staff were unable to provide a policy outlining requirements for Certified Dietary Manager (CDM) certification. During an interview on 2/18/26 at 10:55 AM, the Dietary Manager stated he had not completed a Certified Dietary Manager (CDM) program, and he was unaware that he was required to obtain certification. Record review of personnel records revealed the Dietary Manager was hired approximately two years ago and has not completed or enrolled in a CDM program. During an interview on 2/19/26 at 11:25 AM, the Administrator stated she was unaware the Dietary Manager was required to obtain CDM certification.	F0801		
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 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	F0880		

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F0880 SS = E	Continued from page 13 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 observations, staff interviews, and facility policy review, the facility failed to implement infection prevention and control practices to prevent the transmission of infections. Specifically, the facility failed to ensure staff used Enhanced Barrier Precautions (EBP) during catheter care and failed to perform hand hygiene during wound care for two (2) of three (3) resident care opportunities. (Residents #3	F0880		

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F0880 SS = E	Continued from page 14 and #6) Findings include: Review of facility policy titled, "Enhanced Barrier Precautions," dated 5/27/2024, revealed, "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms…'Indwelling medical devices' would include, indwelling urinary catheters…Enhanced Barrier Precautions are recommended for residents with indwelling medical devices…" Review of facility policy titled, "Handwashing," dated 1/3/2019, revealed, "…When to wash hands…after handling any contaminated items…" Resident #3 During a wound care observation for Resident #3 on 2/19/2026 at 8:30 AM with Licensed Practical Nurse (LPN) #2, LPN #2 failed to follow infection control practices by not performing hand hygiene after removing Resident #3's soiled dressing and before donning clean gloves. During an interview on 2/19/2026 at 8:45 AM, LPN #2 stated she forgot to perform hand hygiene during the wound care procedure. She stated hand hygiene should be performed before donning gloves to help prevent the possible spread of infection. Record review of the Order Summary Report for Resident #3 revealed, "…Cleanse Stage 2 pressure injury to coccyx area with wound cleanser, pat dry, and apply Triad and Opti foam daily until healed every day shift for pressure injury, dated 1/16/2026…" Record review of the Admission Record for Resident #3 revealed the resident was admitted to the facility on 1/6/26 with diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified. A record review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/26, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Resident #6 During an observation on 2/18/26 at 3:00 PM of catheter care with Resident #6, Certified Nursing Assistant (CNA) #2 was observed failing to use Enhanced Barrier	F0880		

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F0880 SS = E	Continued from page 15 Precautions during the procedure, when she failed to wear a gown. During an interview on 2/18/26 at 3:10 PM, CNA #2 stated she was aware Enhanced Barrier Precautions should have been used during catheter care; however, she stated she forgot. CNA #2 stated Enhanced Barrier Precautions are used to prevent the spread of infection between the staff and residents and between residents. She further confirmed failure to follow Enhanced Barrier Precautions could place Resident #6 at risk for infection. Record review of Order Summary Report for Resident #6, revealed, “Clean Foley with soap and water daily every day shift, dated 1/12/2026…” Record review of the Admission Record revealed Resident #6 was admitted to the facility on 2/9/2026 with medical diagnoses including Disorder of Muscle, unspecified and Retention of Urine, unspecified. Record review of Resident #6's quarterly MDS with an ARD of 1/19/2026, revealed under Section C a BIMS score of 8, indicating moderate cognitive impairment. During an interview on 2/19/26 at 9:00 AM, the Administrator and Director of Nursing (DON) confirmed Enhanced Barrier Precautions should have been used during catheter care and that hand hygiene should be performed before donning gloves. They confirmed staff had been trained on these practices and stated these measures are intended to prevent the spread of infection. They further confirmed failure to use Enhanced Barrier Precautions and to perform hand hygiene could place Residents #3 and #6 at increased risk for infection.	F0880		