STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	**1320 WINFIELD STREET P.O. BOX 1288, PRENTISS, Mississippi, 39474**

(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 4/20/26 through 4/23/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F644, F656, F686, F812, F867 and F880. The facility had a census of 47 and was licensed for 55 beds.	F0000		
F0812 SS = E	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: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure food was stored in a manner that maintained	F0812		

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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F0812 SS = E	Continued from page 1 freshness and quality and was properly labeled and dated in accordance with professional standards for food safety for one (1) of two (2) kitchen observations. Findings include:A review of the facility's policy, "Storing: Food and Equipment," revealed, "Team members must store food in a manner that ensures quality, freshness and safeguards against foodborne illnesses…Scope of Responsibility…All team members must follow food and temperature guidelines, labeling, use-by-dates, food storage chart, freezing and leftover guidelines to ensure food and equipment criteria are met…". A record review of the "Safe Training," dated 2/1/25, revealed, "All Food must be properly labeled and dated…Ensure all food is labeled, including: Food stored in its original container, Food not stored in original container…When to Discard…by use-by-date indicated when storing or sooner if quality is an issue or by manufacturer's use-by-date…How Long to Keep…Food should be discarded or used by the use-by date. The use-by date is the last date the manufacturer recommends use of the food and may be referred to as an expiration date…Prepared Food Held more than 24 Hours. Food that has been prepared and will be held for more than 24 hours must be labeled and dated with the following: Name of the product (common name) Preparation date…". On 4/20/26 at 10:36 AM, during an observation and interview with the Assistant Dietary Manager (DD) #2, upon opening refrigerator #3, an odor consistent with decaying cabbage was noted. Three (3) bags of shredded cabbage were observed and confirmed to be expired, including two (2) bags dated 4/5/26 and one (1) bag dated 3/15/26, which appeared deteriorated. During the same observation, six (6) sandwiches prepared for residents were observed in the reach-in cooler without labels or dates. During the interview, DD #2 reported it was the responsibility of all dietary staff to check and rotate dates and remove expired items. She stated the cabbage had been served the previous Thursday and confirmed the sandwiches were prepared that day but were not labeled or dated. On 4/22/26 at 2:55 PM, during an interview with Dietary Manager (DD) #1, accompanied by Assistant Dietary Manager (DD) #2, DD #1 reported her expectation was for all dietary staff to ensure food items were properly dated and labeled and to maintain compliance with food safety practices, including proper stock rotation and disposal of	F0812		

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F0812 SS = E	Continued from page 2 expired items. She reported managerial staff would begin monitoring dietary aides to ensure compliance with labeling, dating, and removal of expired food items. On 4/23/26 at 11:49 AM, during an interview with the Administrator, she was informed of the findings related to expired and undated food items. She reported her expectation was for the dietary department to ensure all food items were properly dated and labeled and that expired food items were discarded.	F0812		
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. §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.	F0550		

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F0550 SS = D	Continued from page 3 §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 privacy during medication administration for one (1) of five (5) residents reviewed for medication administration. Resident #5. Findings include: A review of the facility's policy, "Resident Rights Guidelines for all Nursing Procedures," revised 10/2010, revealed, "…To provide general guidelines for resident rights while caring for the resident. Preparation 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including…b. Resident dignity and respect…". On 4/21/26 at 11:01 AM, during an observation, Licensed Practical Nurse (LPN) #1 entered Resident #5's room to perform an accucheck and insulin administration. She gathered supplies, explained the procedure, and performed a finger stick to obtain a blood glucose level. The door remained open and the privacy curtain was not pulled during the entire procedure. Staff and other residents were observed passing in the hallway while care was being provided. LPN #1 administered (10) units of NovoLog insulin subcutaneously in the abdomen without providing privacy for the resident. On 4/21/26 at 11:28 AM, during an interview with LPN #1, she confirmed she did not close the door or pull the curtain during the accucheck and insulin administration. She reported she should have closed the door and pulled the curtain prior to providing care and acknowledged this was necessary to protect Resident #5's dignity. On 4/22/26 at 2:52 PM, during an interview with the Director of Nursing (DON), she reported LPN #1 should have provided privacy while completing the accucheck and administering the injection. She stated the expectation was for nursing staff to close the door and pull the curtain during care to maintain resident privacy. A record review of the "Admission Record" revealed the facility admitted Resident #5 on 2/2/26 with	F0550		

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F0550 SS = D	Continued from page 4 diagnoses including Type 2 Diabetes Mellitus. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident's cognition was moderately impaired. A record review of the "Order Summary Report" revealed Resident #5 had a physician's order dated 2/2/26 for NovoLog insulin per sliding scale before meals and at bedtime.	F0550		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) was completed accurately to reflect a diagnosis of Schizophrenia and the use of an antipsychotic medication for one (1) of (16) sampled reviewed. Resident #41. Findings include: A review of the facility's policy, "Admission Criteria," revised December 2016, revealed, "Our facility will admit only those residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation…8. Nursing and	F0644		

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F0644 SS = D	Continued from page 5 medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with Medicaid Pre-admission Screening and Resident Review program (PASARR) to the extent practicable. 9. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility…". A record review of the "Admission Record" revealed the facility admitted Resident #41 on 9/19/23 with diagnoses including Schizophrenia. A record review of the "Screening – Questionnaire Status: Submitted (Level I Screening)" revealed Resident #41's "Medications" included Aripiprazole (antipsychotic medication). Further review revealed "Disease Diagnoses" did not include Schizophrenia and "No" was selected to indicate the resident was not taking an antipsychotic medication. A record review of the Comprehensive Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/25/23 (original MDS) revealed Resident #41 had a diagnosis of Schizophrenia. On 4/21/26 at 2:18 PM, during an interview with the Director of Nursing (DON), she reported Resident #41 did not have a PASRR Level II evaluation completed because it was not requested by the independent contractor. On 4/22/26 at 9:48 AM, during a follow-up interview with the DON, she reported Resident #41's PASRR was completed and submitted prior to her becoming the DON in 2024 and stated she was unaware the previous PASRR had been completed inaccurately, as it had not been brought to her attention. On 4/22/26 at 10:29 AM, during an interview with the Consultant, she reported she did not make determinations regarding PASRR Level II evaluations. She stated Resident #41 was admitted with a diagnosis of Schizophrenia and this diagnosis was documented on the initial Minimum Data Set (MDS) in 2023. On 4/23/26 at 11:53 AM, during an interview with the Administrator, she reported staff were currently receiving training on PASRR requirements and stated the expectation was for staff to accurately complete PASRR screenings.	F0644		

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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. (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:	F0656		

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F0656 SS = D	Continued from page 7 Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions related to wound care for one (1) of 16 sampled residents. Resident #1. Findings include: A review of the facility's policy, "Care Plans, Comprehensive Person-Centered," dated 12/2016, revealed, "…A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is…implemented for each resident…" A record review of the "Care Plan Report" revealed Resident #1 had a "Focus" of "Resident has actual skin breakdown…" with an "Interventions" including, "Cleanse Stage 4 pressure ulcer to left ankle with Vashe and pat dry. Apply A&D ointment to peri wound. Apply Aquacel AG to wound bed and cover with gauze and ABD pad. Wrap with conform daily and prn for soilage and dislodgement…" A record review of the "Order Summary Report" revealed Resident #1 had a Physician's Order, dated 4/21/26 to "Cleanse Stage 4 pressure ulcer to the left ankle with Vashe and pat dry. Apply A&D Ointment to per wound. Apply Aquacel AG to wound bed and cover with gauze and ABD pad. Wrap with conform daily and prn (as needed) for soilage and dislodgement…" During an observation on 4/21/26 at 2:20 PM, Registered Nurse (RN) #1 provided wound care for Resident #1's Stage 4 pressure ulcer to the left ankle. RN #1 removed the soiled dressing, performed hand hygiene, cleansed the wound with Vashe, and applied A and D ointment to the peri-wound and Aquacel AG to the wound bed. RN #1 then covered the wound with an ABD pad and wrapped with conform. RN #1 did not apply gauze prior to applying the ABD pad per the resident's care plan intervention. During an interview on 4/21/26 at 2:46 PM, RN #1 confirmed she did not follow the physician's order or the care plan to apply gauze prior to the ABD pad. She reported the gauze was intended to help keep the wound dry and stated it was important for nurses to follow physician orders to prevent complications. During an interview on 4/22/26 at 2:58 PM, during an interview, the Director of Nursing (DON), reported	F0656		

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F0656 SS = D	Continued from page 8 care plans should be followed as written, and all staff should follow the care plan. During an interview on 04/22/26 at 3:08 PM, RN #2/Care Plan and Minimum Data Set (MDS) nurse stated the care plan is individualized for each resident and should be followed. She stated she expects staff to follow care plan while doing all care. A record review of the “Admission Record” revealed the facility initially admitted Resident #1 on 5/23/25 and he had diagnoses including Pressure Ulcer of the left ankle, Stage 4. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (13), which indicated the resident was cognitively intact. A review of Section M revealed he had a Stage 4 pressure ulcer.	F0656		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow physician orders for treatment of a pressure ulcer for one (1) of (1) resident reviewed for wound care. Resident #1. Findings include: A review of the facility’s policy, “Wound Care,”	F0686		

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F0686 SS = D	Continued from page 9 revised June 2018, revealed, "…The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physician's order for the procedure….Steps in the Procedure…8. Apply treatments as indicated…". A record review of the "Order Summary Report" revealed Resident #1 had a Physician's Order, dated 4/21/26 to "Cleanse Stage 4 pressure ulcer to the left ankle with Vashe and pat dry. Apply A&D Ointment to per wound. Apply Aquacel AG to wound bed and cover with gauze and ABD pad. Wrap with conform daily and prn (as needed) for soilage and dislodgement…" On 4/21/26 at 2:20 PM, during an observation, Registered Nurse (RN) #1, assisted by a Certified Nurse Aide (CNA), provided wound care for Resident #1's Stage 4 pressure ulcer to the left ankle. RN #1 removed the soiled dressing, performed hand hygiene, cleansed the wound with Vashe, and applied A and D ointment to the peri-wound and Aquacel AG to the wound bed. RN #1 then covered the wound with an ABD pad and wrapped with conform. RN #1 did not apply gauze prior to applying the ABD pad as ordered. On 4/21/26 at 2:46 PM, during an interview with RN #1, she confirmed she did not follow the physician's order to apply gauze prior to the ABD pad. She reported the gauze was intended to help keep the wound dry and stated it was important for nurses to follow physician orders to prevent complications. On 4/22/26 at 2:58 PM, during an interview with the Director of Nursing (DON), she reported nurses were expected to follow physician orders as written, step by step, when providing wound care. A record review of the "Admission Record" revealed the facility initially admitted Resident #1 on 5/23/25 and he had diagnoses including Pressure Ulcer of the left ankle, Stage 4. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (13), which indicated the resident was cognitively intact. A review of Section M revealed he had a Stage 4 pressure ulcer.	F0686		

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F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F0867		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	**1320 WINFIELD STREET P.O. BOX 1288, PRENTISS, Mississippi, 39474**

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F0867 SS = D	Continued from page 11 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body,	F0867		

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F0867 SS = D	Continued from page 12 or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to ensure food was stored, labeled, and dated in accordance with professional standards for food safety during an annual recertification survey on 11/21/2024 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F812 Findings include: A review of the facility’s policy, "Quality Assurance and Performance Improvement (QAPI) Program," revised August 2017, revealed, "…This facility shall implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals..." A record review of the “Provider History Report” revealed on 11/21/24, the facility was cited “F812-Food Procurement, Store/Prepare/Serve-Sanitary” A record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility’s plan of correction), with a survey date of 11/21/24, revealed the facility received a citation for	F0867		

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F0867 SS = D	Continued from page 13 F812, "…Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards for food safety related to expired foods, overly ripe produce, and scoops stored in dry bins touching food items for one (1) of two (2) kitchen observation…" During the current recertification survey, the facility failed to ensure food was stored in a manner that maintained quality and freshness and was properly labeled and dated in accordance with professional standards for food safety for one (1) of two (2) kitchen observations. On 4/23/26 at 1:01 PM, during an interview with the Administrator, she reported it was important to maintain ongoing monitoring of plans of correction to ensure sustained compliance and prevent a decline in quality of care. She reported the dietary department was cited again due to a failure to maintain consistent monitoring of compliance with food safety practices.	F0867		
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:	F0880		

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F0880 SS = D	Continued from page 14 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to perform hand hygiene to prevent the potential spread of infection during medication administration for one (1) of five (5) residents reviewed for medication	F0880		

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F0880 SS = D	Continued from page 15 administration. Resident #4. Findings include: A review of the facility's policy, "Infection Control Guidelines for All Nursing Procedures," revised April 2024, revealed, "…To provide guidelines for general infection control while caring for residents...General Guidelines 1. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. 5. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol based hand rub…for all the following situations…i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident…". On 4/21/26 at 1:14 PM, during an observation, Licensed Practical Nurse (LPN) #2 administered medication via Percutaneous Endoscopic Gastrostomy (PEG) tube to Resident #4. LPN #2 applied a gown and performed hand hygiene before applying gloves. She verified tube placement by aspiration and auscultation. She then removed her gloves, performed hand hygiene, and applied clean gloves. LPN #2 paused the feeding pump while wearing gloves and proceeded to administer medications via the PEG tube without removing the gloves and performing hand hygiene after contact with the feeding pump, which was in the immediate resident environment. On 4/21/26 at 2:05 PM, during an interview with LPN #2, she confirmed she did not remove gloves and perform hand hygiene after pausing the feeding pump and prior to administering medications. She reported this was an infection control concern and acknowledged residents could develop infections when infection control practices were not followed. On 4/22/26 at 2:55 PM, during an interview with the Director of Nursing (DON), she reported LPN #2 should have performed hand hygiene prior to administering medications via the PEG tube after touching the feeding pump. She stated failure to follow proper hand hygiene practices could result in infection and reported the expectation was for nursing staff to follow infection control guidelines at all times. On 4/23/26 at 9:28 AM, during an interview with Registered Nurse (RN) #3, Infection Preventionist (IP), she reported staff should remove gloves and perform hand hygiene when gloves become contaminated, not only when visibly soiled. She	F0880		

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F0880 SS = D	Continued from page 16 stated failure to perform hand hygiene could result in the spread of infection and negatively impact residents. A record review of the “Admission Record” revealed the facility admitted Resident #4 on 2/3/26 with diagnoses including Cerebral Infarction. A record review of the “Order Summary Report” revealed Resident #4 had a physician’s order dated 2/3/26 for nothing by mouth (NPO) and required all tube feedings and medications to be administered via Percutaneous Endoscopic Gastrostomy (PEG) tube. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/26 revealed Resident #4 required a staff assessment for cognition and had severely impaired cognitive skills for daily decision making.	F0880		