STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey on 5/21/23 through 5/24/23. During the survey the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and cited M225 related to lack of sufficient staffing, M500 related to resident rights, and M610 related to activities of daily living care, and M620 related to urinary catheter care. The census at the time of the survey was 101 with a bed capacity of 105.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.	M 225		7/12/23

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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M 225	Continued From page 1 c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Based on observation, staff and resident interviews, record review and facility policy review the facility failed to assure that there was sufficient qualified nursing staff available at all times to assist the residents in getting the care they needed for three (3) of 24 days of staffing	M 225	A daily staffing grid has been completed at the beginning of each twenty-four hour period since 5/25/23 to ensure sufficient qualified nursing staff was available to provide care to the residents.	

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M 225	Continued From page 2 reviewed. Findings include: Record review of the facility policy titled, "Nursing Services-Staffing" with the latest revision date of 11/17 revealed "1. Staffing-The facility will have sufficient nursing staff twenty-four hours every day to provide nursing and nursing related services to attain or help maintain the highest practicable, physical, mental, and psychosocial well-being of each resident as is determined in the comprehensive assessment and the resident care plan..." An interview on 5/21/23 at 6:50 PM, with Certified Nurse Aide (CNA) #5, revealed she works the 3-11 shift and that they usually have two (2) aides per hall. She revealed it can be a struggle at times, but they (the aides) must use time management to get everything done. Record review revealed that the facility triggered low weekend staffing and the State Agency (SA) entered the facility on a Sunday 05/21/23 at 3:00 PM to observe for any weekend staffing concerns or care concerns related to low staffing. "Staffing Data Report for Fiscal Year 2023 Payroll Based Journal," revealed, "Excessively Low Weekend Staffing Triggered, Triggered = Submitted Weekend Staffing data is excessively low." An interview with the Director of Nursing (DON), on 5/22/23 at 3:30 PM, confirmed they have been experiencing staffing issues and stated they are actively looking for CNAs and have increased their pay rate as an incentive for new hires and included a shift differential as an extra incentive. She revealed they must use agency staffing because they do not have enough facility staff	M 225	All residents have the potential to be affected by this deficient practice. On 5/24/23, the Director of Nursing and Staff Development Nurse were in-serviced by the Administrator on the minimum staffing requirements, that sufficient staff must be maintained on each shift to provide care to the residents and of their responsibility to cover a shift if there is not adequate staff available. On 6/2/23, the Weekend Charge Nurse was in-serviced on the minimum staffing requirements and of responsibility to notify the Director of Nursing or Staff Development Nurse of insufficient staffing on the weekends and of need to notify on-call Nurse. On 6/13/23, Office Personnel who are licensed or certified were informed of requirement to assist with covering a call-in by the Quality Improvement Nurse. A Quality Assurance meeting was held on 5/30/23 to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur. Beginning 5/25/23, the Director of Nursing or Staff Development Nurse will complete a staffing grid daily at the beginning of each twenty-four hour period to ensure sufficient qualified nursing staff is available to provide care to the residents. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding M Tag 225 in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning 7/11/23, the Administrator or Director of Nursing will report any concerns at the	

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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M 225	Continued From page 3 and that staffing has been increasingly difficult since Covid-19. She revealed that she does the nurse staffing schedule, and the Assistant Director of Nursing (ADON) does the aides. She revealed that she addresses call-ins by having a nurse on call during the weekend, so if someone should call in, the nurse will replace that shift, even working as an aide. The SA inquired whether the residents were receiving adequate care, she stated, "We also have several office personnel that are CNA's and come out to assist. She stated, "There have been many days that I have come out of the office and have given showers. She revealed that they staff two (2) aides to a hall, except for A hall that has a lower census. She confirmed that they do not have a shower team and the aides were responsible for giving their assigned halls/units showers. On 5/21/23 at 5:20 PM, an interview with Resident #5's daughter revealed on the right upper side, the resident had a tooth that was broken off at the gum line and the tooth next to that one was decayed. She stated on the lower right side there was also a decayed tooth. She stated Resident #5 was not receiving adequate oral hygiene and that she had spoken with the DON, the Administrator, and the Physician about her concerns that the resident was not receiving adequate oral care since her teeth appeared unbrushed. She stated after speaking to several staff members, her mother was placed on a daily brushing and rinse schedule and was also given an antibiotic to treat gingivitis, and this has improved the appearance of her mother's teeth. On 5/24/23 at 11:15 AM, an interview with the DON revealed that according to the documented care logs, the resident did not receive oral care each day as needed for dependent residents' oral	M 225	Quality Assurance Committee Meeting, then monthly for three months until substantial compliance is achieved with M Tag 225. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with M Tag 225.	

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M 225	Continued From page 4	M 225		

health. She confirmed the facility failed to ensure the resident received daily oral hygiene and this could have led to the resident's gingivitis diagnosis.

Record review of Completed Care Details for Personal Hygiene Completed revealed for the months of March, April, and May, the resident did not receive oral care on these dates: 3/2/23, 3/4/23, 3/5/23, 3/9/23, 3/12/23, 3/17/23, 3/19/23, 3/24/23, 3/28/23, 3/29/23, 4/4/23, 4/8/23, 4/10/23, 4/13/23, 4/18/23, 4/19/23, 4/22/23, 4/23/23, 5/2/23, 5/3/23, 5/6/23, 5/9/23, 5/12/23, 5/13/23, 5/16/23, 5/19/23, 5/20/23, 5/21/23, and 5/22/23.

Record review of Electronic Medication Administration Record revealed the resident did not receive the ordered teeth brushing or mouth rinse on 5/13/23.

An observation on 5/22/23 at 5:45 PM, from C and D wing nurses' station, revealed three (3) call lights sounding on the call alert system behind the nurses' desk. SA observed call lights blink for approximately 13 minutes. One (1) aide was observed passing out supper trays on C hall with no other staff observed in the hallways. SA observed two (2) nurses seated behind the nurse's station with their heads down. SA inquired from Licensed Practical Nurse (LPN) # 5 as to what that sound was that was alarming. She stated, "That's the call light system." SA inquired how the system worked and she stated, "The residents push their call light when they need help or need something, and it will sound out here." SA inquired from LPN #5 whether she should go and answer the light. She replied, "Yes." SA observed both nurses seated behind the desk get up to respond to the call lights after being cued.

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M 225	Continued From page 5 An interview with Licensed Practical Nurse (LPN) #3 on 5/23/23 at 9:10 AM, revealed that they have three (3) aides today on the D wing. She revealed that two (2) aides work the floor and one (1) will do the showers. She stated, "I'm not going to lie to you; we are having staffing issues." She stated, "Nobody wants to work right now, and I think everyone is having staffing issues." An interview on 5/23/23 at 9:45 AM, with Registered Nurse (RN) # 2, revealed that she works Monday-Friday as the charge nurse. She stated she usually works 9-10 hours a day and stated that the facility does not have enough staff to take care of the residents. She revealed that after Covid -19, the hospitals began sending more and more residents to the facility with higher acuity. She stated, "They think we are the ICU step down." She revealed that the facility was having trouble finding and keeping staff and that they have a lot of "high-level care" residents that require one on one, and they do not have the staff to properly care for them. She revealed that the aides are overwhelmed with all that they have to do with the available staff and stated, "It's frustrating." An interview on 5/23/23 at 4:10 PM, with the Assistant Director of Nursing (ADON), confirmed that the facility has been experiencing staffing concerns. She revealed that they've had trouble with staffing since Covid-19, but more so in the past year. She stated that they have just as many call-ins throughout the week as they do on the weekends. She revealed the facility has tried to discipline staff with excessive call-ins with verbal warnings, write-ups, and suspension but it doesn't work and stated, "It doesn't do any good. Sometimes we struggle, especially with showers. Sometimes they (the residents) don't get a	M 225		

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 6	M 225		

shower, or it may be the next day. It can be a struggle; We just need more staff." She revealed that they do use an agency, but those shifts must be scheduled ahead of time, and agency staff were only required to work two (2) weekends out of a month. She revealed that she often does shift trading with the aides to get a shift filled and stated that money doesn't work anymore, people still call in. She revealed the facility has increased the base pay for the aides and given a shift differential. She stated, "We've done everything. We do have a lot of high-acuity residents here." When the SA inquired about the facility's willingness to hold off on admissions due to low staffing, she shook her head and stated, "No, there is no way that they are going to do that."

An interview on 5/24/23 at 10:20 AM, with Certified Nurse Aide (CNA) #6 revealed that the staffing has been a concern for a while. She revealed she had spoken with the administration, but they told her, "We know," and that the facility was using agency staffing but stated, "They are not reliable." She stated that the agency comes in late which makes it harder on them because they must cover the residents until agency arrives. She revealed the residents are not being cared for properly. She stated that this past Monday, 5/22/23 they had call-ins and none of the residents got a shower that day, just a wash-up in their bed. She revealed that the facility has a lot of high-level of care residents that must be transferred with lifts and must be fed.

An interview with Resident # 3 on 5/24/23 at 10:35 AM, revealed the facility had a change in the administration about two (2) years ago and since then the care has gone down. She revealed that the aides work hard and provide good care, it's just not enough of them. She stated, "They

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 225	Continued From page 7	M 225		

care for the residents, and they are doing all they can do." She stated when they have two (2) aides to a hall, they don't get everything they need. She revealed that when they are short it takes a long time to get assistance after pushing the call light and she also revealed there are days when she doesn't get a shower. She stated, "It's not their fault, it's management's." She stated the two (2) aides usually have an entire hall and that's over twenty-something people to take care of.

An interview on 5/24/23 at 3:35 PM, with the Corporate Nurse confirmed they were having staffing concerns and confirmed that the facility failed to have sufficient staff for three (3) of the 24 days reviewed on the staffing grid and the staff working schedule with the dates of 3/25/23, 5/20/23 and 5/22/23. She stated, "We have done everything we can concerning staffing." She stated, "I'm sure we're not the only ones like this." The Corporate Nurse confirmed that the facility had not held off on admissions due to "low staffing."

An interview on 5/24/23 at 3:40 PM, with the Director of Nursing (DON), revealed they are continuing to try and come up with ideas to help resolve the call-ins. She revealed some of the aides are now working sixteen hours on the weekend and taking the week off and that has helped. They've gotten a pay increase along with shift differential. She stated that money does not matter with the aides at this point. She acknowledges that the facility failed to meet the requirements for sufficient staff for three (3) of the 24 days reviewed on the staffing grid and working schedule with the dates of 3/25/23, 5/20/23 and 5/22/23.

On 5/22/23 at 4:00 PM, an observation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 8	M 225		

interview revealed Resident #39 sitting in a wheelchair in his room. Resident #39 revealed he has not had a shower today and that he needs to be shaved. Resident stated, "I've been waiting all day and they told me they didn't have anybody to do it." Resident observed to have long facial hair.

On 5/22/23 at 4:05 PM, an observation and interview with CNA # 7 revealed she works 3-11 shift. She revealed that the day shift was responsible for all the showers. She stated that today, all the odd rooms, which are located on the left side of the hall would have been scheduled for a shower. She confirmed that the resident was in an odd number room, so he should have got a shower on the 7-3 shift today. She confirmed that the facility doesn't have a shower team. The day shift aide assigned to Resident #39 would have been responsible for his shower. She confirmed that Resident #39 did have long facial hair and that he needed to be shaved. She stated, "He can tell you if he had a shower today, he knows. If he tells you that he didn't get a shower today, then he didn't."

On 5/22/23 at 4:15 PM, an observation and interview with the DON confirmed that Resident #39 had not been showered or shaved and that today was the residents shower day. She revealed the resident should have been showered and shaved today.

Record review of Resident #39's Activities of Daily Living (ADL's) revealed under," Reason not bathed dated 5/22/23 and timed 11:45 AM" documentation recorded, "No."

Record review of Physician Orders revealed the facility had a total of 26 residents requiring the use of a total lift and two (2) staff members for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 225	Continued From page 9 transfers. The facility provided documentation on letterhead dated 5/24/23 with the attached census, highlighting a total number of 16 residents, which require two (2) person physical assistance for most of their activities of daily living (ADL's). The facility provided documentation on letterhead dated 5/24/23 with the attached census, highlighting a total number of 17 residents, which require staff assistance to be fed.	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 225	Continued From page 10	M 225		

Level III

Based on observation, staff and resident interviews, record review and facility policy review the facility failed to assure that there was sufficient qualified nursing staff available at all times to assist the residents in getting the care they needed for three (3) of 24 days of staffing reviewed.

Findings include:

Record review of the facility policy titled, "Nursing Services-Staffing" with the latest revision date of 11/17 revealed "1. Staffing-The facility will have sufficient nursing staff twenty-four hours every day to provide nursing and nursing related services to attain or help maintain the highest practicable, physical, mental, and psychosocial well-being of each resident as is determined in the comprehensive assessment and the resident care plan..."

An interview on 5/21/23 at 6:50 PM, with Certified Nurse Aide (CNA) #5, revealed she works the 3-11 shift and that they usually have two (2) aides per hall. She revealed it can be a struggle at times, but they (the aides) must use time management to get everything done.

Record review revealed that the facility triggered low weekend staffing and the State Agency (SA) entered the facility on a Sunday 05/21/23 at 3:00 PM to observe for any weekend staffing concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 225	Continued From page 11	M 225		

or care concerns related to low staffing. "Staffing Data Report for Fiscal Year 2023 Payroll Based Journal," revealed, "Excessively Low Weekend Staffing Triggered, Triggered = Submitted Weekend Staffing data is excessively low."

An interview with the Director of Nursing (DON), on 5/22/23 at 3:30 PM, confirmed they have been experiencing staffing issues and stated they are actively looking for CNAs and have increased their pay rate as an incentive for new hires and included a shift differential as an extra incentive. She revealed they must use agency staffing because they do not have enough facility staff and that staffing has been increasingly difficult since Covid-19. She revealed that she does the nurse staffing schedule, and the Assistant Director of Nursing (ADON) does the aides. She revealed that she addresses call-ins by having a nurse on call during the weekend, so if someone should call in, the nurse will replace that shift, even working as an aide. The SA inquired whether the residents were receiving adequate care, she stated, "We also have several office personnel that are CNA's and come out to assist. She stated, "There have been many days that I have come out of the office and have given showers. She revealed that they staff two (2) aides to a hall, except for A hall that has a lower census. She confirmed that they do not have a shower team and the aides were responsible for giving their assigned halls/units showers.

On 5/21/23 at 5:20 PM, an interview with Resident #5's daughter revealed on the right upper side, the resident had a tooth that was broken off at the gum line and the tooth next to that one was decayed. She stated on the lower right side there was also a decayed tooth. She stated Resident #5 was not receiving adequate

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 12	M 225		

oral hygiene and that she had spoken with the DON, the Administrator, and the Physician about her concerns that the resident was not receiving adequate oral care since her teeth appeared unbrushed. She stated after speaking to several staff members, her mother was placed on a daily brushing and rinse schedule and was also given an antibiotic to treat gingivitis, and this has improved the appearance of her mother's teeth.

On 5/24/23 at 11:15 AM, an interview with the DON revealed that according to the documented care logs, the resident did not receive oral care each day as needed for dependent residents' oral health. She confirmed the facility failed to ensure the resident received daily oral hygiene and this could have led to the resident's gingivitis diagnosis.

Record review of Completed Care Details for Personal Hygiene Completed revealed for the months of March, April, and May, the resident did not receive oral care on these dates: 3/2/23, 3/4/23, 3/5/23, 3/9/23, 3/12/23, 3/17/23, 3/19/23, 3/24/23, 3/28/23, 3/29/23, 4/4/23, 4/8/23, 4/10/23, 4/13/23, 4/18/23, 4/19/23, 4/22/23, 4/23/23, 5/2/23, 5/3/23, 5/6/23, 5/9/23, 5/12/23, 5/13/23, 5/16/23, 5/19/23, 5/20/23, 5/21/23, and 5/22/23.

Record review of Electronic Medication Administration Record revealed the resident did not receive the ordered teeth brushing or mouth rinse on 5/13/23.

An observation on 5/22/23 at 5:45 PM, from C and D wing nurses' station, revealed three (3) call lights sounding on the call alert system behind the nurses' desk. SA observed call lights blink for approximately 13 minutes. One (1) aide was observed passing out supper trays on C hall with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 13	M 225		

no other staff observed in the hallways. SA observed two (2) nurses seated behind the nurse's station with their heads down. SA inquired from Licensed Practical Nurse (LPN) # 5 as to what that sound was that was alarming. She stated, "That's the call light system." SA inquired how the system worked and she stated, "The residents push their call light when they need help or need something, and it will sound out here." SA inquired from LPN #5 whether she should go and answer the light. She replied, "Yes." SA observed both nurses seated behind the desk get up to respond to the call lights after being cued.

An interview with Licensed Practical Nurse (LPN) #3 on 5/23/23 at 9:10 AM, revealed that they have three (3) aides today on the D wing. She revealed that two (2) aides work the floor and one (1) will do the showers. She stated, "I'm not going to lie to you; we are having staffing issues." She stated, "Nobody wants to work right now, and I think everyone is having staffing issues."

An interview on 5/23/23 at 9:45 AM, with Registered Nurse (RN) # 2, revealed that she works Monday-Friday as the charge nurse. She stated she usually works 9-10 hours a day and stated that the facility does not have enough staff to take care of the residents. She revealed that after Covid -19, the hospitals began sending more and more residents to the facility with higher acuity. She stated, "They think we are the ICU step down." She revealed that the facility was having trouble finding and keeping staff and that they have a lot of "high-level care" residents that require one on one, and they do not have the staff to properly care for them. She revealed that the aides are overwhelmed with all that they have to do with the available staff and stated, "It's frustrating."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 225	Continued From page 14 An interview on 5/23/23 at 4:10 PM, with the Assistant Director of Nursing (ADON), confirmed that the facility has been experiencing staffing concerns. She revealed that they've had trouble with staffing since Covid-19, but more so in the past year. She stated that they have just as many call-ins throughout the week as they do on the weekends. She revealed the facility has tried to discipline staff with excessive call-ins with verbal warnings, write-ups, and suspension but it doesn't work and stated, "It doesn't do any good. Sometimes we struggle, especially with showers. Sometimes they (the residents) don't get a shower, or it may be the next day. It can be a struggle; We just need more staff." She revealed that they do use an agency, but those shifts must be scheduled ahead of time, and agency staff were only required to work two (2) weekends out of a month. She revealed that she often does shift trading with the aides to get a shift filled and stated that money doesn't work anymore, people still call in. She revealed the facility has increased the base pay for the aides and given a shift differential. She stated, "We've done everything. We do have a lot of high-acuity residents here." When the SA inquired about the facility's willingness to hold off on admissions due to low staffing, she shook her head and stated, "No, there is no way that they are going to do that." An interview on 5/24/23 at 10:20 AM, with Certified Nurse Aide (CNA) #6 revealed that the staffing has been a concern for a while. She revealed she had spoken with the administration, but they told her, "We know," and that the facility was using agency staffing but stated, "They are not reliable." She stated that the agency comes in late which makes it harder on them because they must cover the residents until agency arrives.	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 15 She revealed the residents are not being cared for properly. She stated that this past Monday, 5/22/23 they had call-ins and none of the residents got a shower that day, just a wash-up in their bed. She revealed that the facility has a lot of high-level of care residents that must be transferred with lifts and must be fed. An interview with Resident # 3 on 5/24/23 at 10:35 AM, revealed the facility had a change in the administration about two (2) years ago and since then the care has gone down. She revealed that the aides work hard and provide good care, it's just not enough of them. She stated, "They care for the residents, and they are doing all they can do." She stated when they have two (2) aides to a hall, they don't get everything they need. She revealed that when they are short it takes a long time to get assistance after pushing the call light and she also revealed there are days when she doesn't get a shower. She stated, "It's not their fault, it's management's." She stated the two (2) aides usually have an entire hall and that's over twenty-something people to take care of. An interview on 5/24/23 at 3:35 PM, with the Corporate Nurse confirmed they were having staffing concerns and confirmed that the facility failed to have sufficient staff for three (3) of the 24 days reviewed on the staffing grid and the staff working schedule with the dates of 3/25/23, 5/20/23 and 5/22/23. She stated, "We have done everything we can concerning staffing." She stated, "I'm sure we're not the only ones like this." The Corporate Nurse confirmed that the facility had not held off on admissions due to "low staffing." An interview on 5/24/23 at 3:40 PM, with the Director of Nursing (DON), revealed they are	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 16	M 225		

continuing to try and come up with ideas to help resolve the call-ins. She revealed some of the aides are now working sixteen hours on the weekend and taking the week off and that has helped. They've gotten a pay increase along with shift differential. She stated that money does not matter with the aides at this point. She acknowledges that the facility failed to meet the requirements for sufficient staff for three (3) of the 24 days reviewed on the staffing grid and working schedule with the dates of 3/25/23, 5/20/23 and 5/22/23.

On 5/22/23 at 4:00 PM, an observation and interview revealed Resident #39 sitting in a wheelchair in his room. Resident #39 revealed he has not had a shower today and that he needs to be shaved. Resident stated, "I've been waiting all day and they told me they didn't have anybody to do it." Resident observed to have long facial hair.

On 5/22/23 at 4:05 PM, an observation and interview with CNA # 7 revealed she works 3-11 shift. She revealed that the day shift was responsible for all the showers. She stated that today, all the odd rooms, which are located on the left side of the hall would have been scheduled for a shower. She confirmed that the resident was in an odd number room, so he should have got a shower on the 7-3 shift today. She confirmed that the facility doesn't have a shower team. The day shift aide assigned to Resident #39 would have been responsible for his shower. She confirmed that Resident #39 did have long facial hair and that he needed to be shaved. She stated, "He can tell you if he had a shower today, he knows. If he tells you that he didn't get a shower today, then he didn't."

On 5/22/23 at 4:15 PM, an observation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 225	Continued From page 17 interview with the DON confirmed that Resident #39 had not been showered or shaved and that today was the residents shower day. She revealed the resident should have been showered and shaved today. Record review of Resident #39's Activities of Daily Living (ADL's) revealed under," Reason not bathed dated 5/22/23 and timed 11:45 AM" documentation recorded, "No." Record review of Physician Orders revealed the facility had a total of 26 residents requiring the use of a total lift and two (2) staff members for transfers. The facility provided documentation on letterhead dated 5/24/23 with the attached census, highlighting a total number of 16 residents, which require two (2) person physical assistance for most of their activities of daily living (ADL's). The facility provided documentation on letterhead dated 5/24/23 with the attached census, highlighting a total number of 17 residents, which require staff assistance to be fed.	M 225		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of	M 500		7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 500	Continued From page 18 the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;	M 500		

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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M 500	Continued From page 19 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 500	Continued From page 20 law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented	M 500		

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 500	Continued From page 21 by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide dignity to residents as evidenced by leaving urinary catheter bags uncovered for one (1) of nine (9) residents with a catheter, Resident #244. Facility failed to serve meals trays concurrently at a table of three (3) residents in the dining room for two (2) of four (4) meals observed for Resident #20, #39, and #295. Findings include: Review of the facility policy titled, "Dignity and Respect", with the latest revision date of 7/22 revealed, "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." Review of the facility policy titled, "Resident Tray Service and Delivery", with the latest revision date of 5/18, revealed, "#6. Meal tray delivery-dining room ... j. Trays are served concurrently to all residents seated at the same table."	M 500	Resident #244 urinary drainage bag was covered with a privacy bag on 5/21/23 by Licensed Practical Nurse #1. Beginning 5/23/23, resident #295 was observed at each meal by the Charge Nurse for concurrent meal tray delivery without incident until resident was discharged on 6/1/23. Since 5/23/23, resident #39 is being observed at each meal by the Charge Nurse for concurrent meal tray delivery without incident. Since 5/23/23, resident #20 is being observed at each meal by the Charge Nurse for concurrent meal tray delivery without incident. All residents that have indwelling catheters and all residents that are served meals in the dining room have the potential to be affected by this deficient practice. No other residents have been identified as being affected by this deficient practice. Weekend Charge Nurse was in-serviced on Resident Tray Service and Delivery and keeping urinary drainage bags covered on 6/2/23 by the Director of Nursing. Charge Nurses were in-serviced on Resident Tray	

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 500	Continued From page 22 Resident #244 A record review of a statement on facility letterhead written by the Director of Nursing and dated 5/23/23, revealed, "Our policy regarding catheter care, does not include privacy bag/cover." An observation on 05/21/23 at 4:55 PM, revealed Resident #244 lying in bed, with the bed against the left wall and the resident facing the doorway. Resident #244's urinary catheter bag and tubing were exposed with approximately 300 cc (cubic centimeters) of urine in the catheter bag with no privacy covering over the urinary drainage bag. An observation and interview on 05/21/23 at 6:05 PM, revealed Resident #244 lying in bed. There was no privacy bag covering the urinary catheter bag. The bag was visible to anyone entering the room. An interview at the same time with Licensed Practical Nurse (LPN) #1 confirmed that there was no privacy covering for the urinary bag, which is a dignity issue for the resident. An observation and interview on 05/21/23 at 6:20 PM, with the Director of Nurses (DON) confirmed Resident #244's catheter bag was not in a privacy bag and she revealed this was a dignity issue for the resident. A record review of Resident #244's Face Sheet revealed the resident was admitted to the facility on 5/04/23 with diagnoses including Encephalopathy, Unspecified injury of urethra, Injury of the Prostate, and Benign Prostatic Hyperplasia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of	M 500	Service and Delivery on 6/6/23 by the Director of Nursing. Nursing Staff was in-serviced on Residents Rights, Respect and Dignity, Resident Tray Service and Delivery and keeping urinary drainage bags covered on 6/13/23 by the Director of Nursing. A Quality Assurance meeting was held on 5/30/23 to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur. Beginning 5/22/23, The Director of Nursing or Staff Development Nurse will check all residents with indwelling catheters to ensure a privacy bag is in place weekly for four weeks, then monthly for three months. Beginning 6/8/23, the Director of Nursing or Staff Development Nurse along with the Dietary Manager will do a Joint Meal Service Review weekly for four weeks to monitor resident tray service and delivery and then resume monthly per facility policy. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding M Tag 500 in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning 7/11/23, the Administrator or Director of Nursing will report any concerns at the Quality Assurance Committee Meeting, then monthly for three months until substantial compliance is achieved with M Tag 500. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with M Tag 500.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 500	Continued From page 23 5/11/2023 revealed Resident #244 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident # 295, #20 and #39 A dining observation on 5/21/23 at 5:35 PM, of the main dining room revealed Resident #295 was served a supper tray at 5:41 PM. The plate was covered, and staff nor resident made any attempts to remove the cover. Resident # 295 was seated at a table with Resident # 20 and Resident # 39. After approximately five (5) minutes, Resident #295 was observed still seated at the table with a covered plate. He began to question multiple staff members as they walked by passing out dining trays when he could start eating his meal. Resident #295 stated, "They (the staff) told me not to eat it until the others got their tray." Staff was observed removing the plate cover for Resident #295 and he began eating at 5:50 PM. Resident #20 and Resident #39 had not received their tray. Resident #39 left the table and stated, "I'm going to my room, I've got a sub sandwich I can eat." Resident # 20 continued to wait and inquired from the staff, "Where's mine?" Certified Nurse Aide (CNA) #5 told Resident #20 that Dietary was working on her tray and it was coming soon. Resident #20 stated, "Well it better be, or I'm going to sue." Resident #295 finished eating and left the dining room at 6:05 PM. Resident #20 received her tray at 6:12 PM. An interview on 5/21/23 at 6:29 PM, with Registered Nurse #1 (RN), the State Agency (SA) inquired about the process for distributing dining trays to a table with multiple residents and she stated, "It usually doesn't happen like this.	M 500		

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 500	Continued From page 24 We're supposed to give those residents trays at the same time." An interview on 5/21/23 at 6:31 PM, with Licensed Practical Nurse #1 (LPN) confirmed that Resident # 295 was served a tray and finished his supper meal before Resident #20, who was sitting at the same table, received her tray. She stated, "I did that, I messed up." She stated, "All the residents at the table should be given their trays at the same time." An observation of the dining room on 05/22/23 at 11:20 AM, revealed staff not providing trays to all the residents that are seated at the same table. Further observation revealed staff members pulling trays off the hall cart and distributing the trays in the dining room without ensuring all residents seated at the same table had received a tray first. An interview with the Dietary Manager (DM) on 5/22/23 at 11:40 AM, revealed they typically try and place residents from the same hall at the same table. She revealed they need to work on things. She confirmed that all residents at the same table should be served at the same time before serving at another table and a resident shouldn't be told that they have to wait on the others at the table to get a tray before they can start eating. An interview with the DON on 5/22/23 at 11:55 AM, confirmed that all residents eating a meal at a table in the dining room should be served at the same time. Record review of the Face Sheet revealed Resident # 295 was admitted to the facility on 5/12/23 with diagnoses that included	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 500	Continued From page 25 Encephalopathy, Cerebral Infarction due to embolism, Hemiplegia and Hemiparesis affecting right dominant side. Record review of Resident # 295's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/17/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 11, which indicated resident is moderately cognitively impaired. Record review of the Face Sheet revealed Resident #39 was admitted to the facility on 9/18/20 with diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with hyperglycemia, and Unspecified Dementia without behavior disturbance. Record review of Resident #39's MDS with an ARD of 5/19/23 revealed a BIMS score of 9, which indicated resident is moderately cognitively impaired. Record review of the Face Sheet revealed Resident #20 was admitted to the facility on 11/13/18 with diagnoses that included Emphysema, Heart Failure, and Dementia without behavior disturbance. Record review of the MDS with an ARD of 4/11/23 revealed under section C a BIMS score of 12, which indicates Resident #20 is moderately cognitively impaired.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well	M 610		7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 26 being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level III Based on observation, staff, resident, and resident representative interviews, record review, and facility policy review, the facility failed to provide personal hygiene as evidenced by long, jagged nails with brown substance underneath nails, unshaven facial hair, unbathed, and poor oral hygiene for three (3) of 21 sampled residents. Resident #5, #39, #85 Findings included: Record review of facility policy titled, "A.M. Care", dated 10/17, revealed, "Purpose: to prepare the resident for their day, to maintain oral health and bodily hygiene, to provide for physical comfort, to maintain the resident's desired physical appearance, to observe the resident's physical and emotional state."	M 610	Resident # 5 has received oral care daily since 5/24/23. Resident # 5 had a dental consult on 06/01/23. Resident # 5 has a consult scheduled with an Oral Surgeon on 6/20/23. On 6/6/23, the Primary Care Physician started resident # 5 on antibiotic therapy by mouth twice daily for ten days prior to oral surgery consult. Resident # 39 received a shower and facial grooming on 5/22/23. Resident # 85 received nail care to include trimming and cleaning and facial grooming on 5/22/23. All residents have the potential to be affected by this deficient practice. No other residents have been identified as being affected by this deficient practice. Nursing Staff was in-serviced on providing Activities of Daily Living care for dependent residents to maintain grooming, personal and oral hygiene to include bathing, facial grooming, nail care and oral care on 6/13/23 by the Director of Nursing. The Activities of Daily Living Documentation was modified to include specific documentation on oral care, nail care and facial grooming on 6/13/23. A	

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 27 Record review of facility policy titled, "Activities of Daily Living", dated 12/20, revealed, "Policy: An Activities of Daily Living flow sheet (ADL) will be utilized by the facilities and documented on a daily basis by the CNA (Certified Nursing Assistant) to reflect actual care rendered the resident." Record review of facility policy titled, "Oral Hygiene", dated 10/17, revealed, "Purpose: to clean the mouth, teeth and gums, to remove particles of food, to remove bacteria and odor, to provide comfort to the resident, to keep the mouth moist". The policy also revealed, "inspect mouth and gums for irritation and open areas" and "observe the resident's mouth for dryness, redness, sores and general condition". Resident #5 An interview with Resident #5's daughter on 5/21/23 at 5:20 PM, revealed on the right upper side, the resident had a tooth that was broken off at the gum line and the tooth next to that one was decayed. She stated on the lower right side there was also a decayed tooth. She stated Resident #5 was not receiving adequate oral hygiene and that she had spoken with the Director of Nursing (DON), the Administrator, and the Physician about her concerns that the resident was not receiving adequate oral care since her teeth appeared unbrushed. She stated after speaking to several staff members, her mother was placed on a daily brushing and rinse schedule and was also given an antibiotic to treat gingivitis and this has improved the appearance of her mother's teeth. She stated her main concern was she wanted to know that her mother was comfortable and not in pain.	M 610	Quality Assurance meeting was held on 5/30/23 to discuss findings from survey exit and systematic changes needed to ensure this deficient practice does not reoccur. Beginning 6/13/23, the Director of Nursing or Staff Development Nurse will make rounds to ensure that the Activities of Daily Living for dependent residents is being provided to include oral care, nail care, bathing and facial grooming three times weekly for four weeks, then monthly for four months. Beginning 6/13/23, the Director of Nursing or Staff Development Nurse will monitor Activities of Daily Living documentation on five residents to ensure oral care, nail care, bathing and facial grooming is documented three times weekly for four weeks, then monthly for three months. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding M Tag 610 in the Department Head Meeting weekly for four weeks then monthly for three months. Beginning 7/11/23, the Administrator or Director of Nursing will report any concerns at the Quality Assurance Committee Meeting, then monthly for three months until substantial compliance is achieved with M Tag 610. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with M Tag 610.	

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 28 An observation on 5/21/23 at 5:20 PM, of Resident #5's mouth revealed slight redness noted, but the daughter stated that this was much improved since the resident started on an antibiotic. An observation and interview with the DON on 5/23/23 at 9:05 AM, revealed the resident had a broken tooth and was started on antibiotics for a mouth infection. She stated an x-ray was also done to ensure her tooth was not abscessed. The DON revealed the broken tooth on the right upper side and a decayed tooth on the lower right and one on the upper right side. Resident #5's teeth appear clean except for a small amount of food. She stated the physician ordered daily brushing of her teeth after the evening meal and a mouth rinse to ensure oral care was done. An interview with the DON on 5/24/23 at 11:15 AM, revealed that according to the documented care logs, the resident did not receive oral care each day as needed for dependent residents' oral health. She confirmed the facility failed to ensure the resident received oral hygiene and this could have led to gingivitis. During an interview with the DON on 5/24/23 at 1:55 PM, she confirmed that according to the documentation in the care log, the resident did not receive oral hygiene two times each day as directed in the care plan. She confirmed that gingivitis is mainly caused by poor oral hygiene and the resident was diagnosed with gingivitis. She confirmed the facility failed to provide adequate oral hygiene which could have led to her gingivitis and teeth concerns. Record review of Completed Care Details for Personal Hygiene Completed revealed for the	M 610		

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	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 29	M 610		

months of March, April, and May, the resident did not receive oral care on these dates: 3/2/23, 3/4/23, 3/5/23, 3/9/23, 3/12/23, 3/17/23, 3/19/23, 3/24/23, 3/28/23, 3/29/23, 4/4/23, 4/8/23, 4/10/23, 4/13/23, 4/18/23, 4/19/23, 4/22/23, 4/23/23, 5/2/23, 5/3/23, 5/6/23, 5/9/23, 5/12/23, 5/13/23, 5/16/23, 5/19/23, 5/20/23, 5/21/23, and 5/22/23.

Record review of Electronic Medication Administration Record revealed the resident did not receive the ordered teeth brushing or mouth rinse on 5/13/23.

Record review of Departmental Note dated 4/25/23, revealed, physician saw resident at facility regarding tooth pain. New order for Doxycycline, to brush teeth each night after eating, and to swab gums with peri guard.

Record review of Physician's Progress Notes dated 4/25/23 revealed, "Has Gingivitis. Has broken incisor tooth upper right. No pain to palpation. No lymphadenopathy in neck. Will give local treatment with chlorohexidine mouth rinse, tooth brushing, and PO (by mouth) antibiotics."

Record review of Physician's Progress Notes dated 5/2/23 revealed, "Mouth Gingivitis much improved. Will continue daily mouth care and teeth brushing. Does have plaque. Not a candidate for deep cleaning. Right upper broken tooth. Not infected. No abscess noted on facial x-ray."

Record review of Face Sheet revealed Resident #5 was admitted to the facility on 10/21/2014 with diagnoses that included Alzheimer's Disease, Dementia, Anxiety Disorder, and Depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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M 610	Continued From page 30	M 610		

Record review of quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/28/23, revealed a Brief Interview for Mental Status (BIMS) of 99 which indicated severe cognitive impairment and inability to complete the interview.

Resident #85

Observation on 05/22/23 at 11:39 AM, revealed Resident #85 sitting in his wheelchair, bilateral fingernails approximately one-half (1/2) inch long and jagged past the tip of fingers, and a brown substance was under each nail. Facial hair was approximately 1/2 inch long and was noted to cheeks, chin and above the residents' lip.

Observation on 05/22/23 at 2:00 PM, Resident #85 sitting in the dining room at activities. A red stain was observed around his mouth and on his chin. His nails were long and jagged with a brown substance noted. Facial hair was approximately (approx) 1/2 inch long to his chin, above his lip and to the sides of his cheeks.

Observation on 05/22/23 at 3:39 PM, Resident #85 sitting in the front foyer with other residents. Visitors observed entering and exiting facility. Resident was noted with a red stain around his mouth area and on his chin. His nails were long and jagged and had a brown substance noted under the nails. Facial hair approx. 1/2 inch long to his chin, above his lip and to the sides of his cheeks.

An observation and interview on 05/22/23 at 4:00 PM, with CNA#1 confirmed Resident #85 had "spaghetti" on his face and that his nails were long and jagged, and had a brown substance under each nail. She stated it doesn't look like he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 31	M 610		

has had a shower and been shaved in a while. She revealed she would make sure he got taken care of this evening.

An observation and interview on 05/22/23 at 4:10 PM, with the DON revealed Resident #85 sitting in the dining room in his wheelchair. The DON confirmed that he needed to be shaved, and he had spaghetti on his face since that's what they had for lunch. She confirmed his nails were long and jagged with a brown substance underneath. She revealed he could cut himself and he could get an infection. She stated, "Do you have any staff," and continued to state that the facility had some staffing problems lately and wasn't sure who got showers today but would make sure he got taken care of right away.

An interview on 05/23/23 at 11:25 AM, with CNA #2 revealed she worked yesterday 7a-3p and the residents on her B-hall only got hygiene care which was a "wipe down." She revealed Resident #85 only got a wipe down and didn't get a shower yesterday like he was supposed to. She stated none of the residents got a shower yesterday on her shift because there was only two aides on B-hall and it is a very busy hall with a lot of two people assist. She revealed one aide can't work the Hoyer-lift alone. She stated it is very frustrating and she has reported this several times to upper management.

A record review of Resident #85's Face Sheet revealed the resident was admitted to the facility on 8/12/2022 with diagnoses which included Metabolic Encephalopathy and Chronic obstructive pulmonary disease.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

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TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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) COMPLETE DATE
M 610	Continued From page 32 4/24/2023 revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. Resident #39 An observation and interview on 5/22/23 at 4:00 PM, revealed Resident #39 sitting in a wheelchair in his room. Resident #39 revealed he has not had a shower today and that he needs to be shaved. He stated, "I've been waiting all day and they told me they didn't have anybody to do it." Resident observed to have long facial hair. An observation and interview on 5/22/23 at 4:05 PM, with Certified Nurse Aide (CNA) # 7 revealed she works 3-11 shift. She revealed that the day shift was responsible for all the showers. She stated that today, all the odd rooms, which are located on the left side of the hall would have been scheduled for a shower. She confirmed that the resident was in an odd number room, so he should have got a shower on the 7-3 shift today. She confirmed that the facility doesn't have a shower team, but the day shift aide assigned to Resident #39 would have been responsible for his shower and she confirmed that Resident #39 did have long facial hair and that he needed shaved. She stated, "He can tell you if he had a shower today, he knows. If he tells you that he didn't get a shower today, then he didn't." An observation and interview with the DON on 5/22/23 at 4:15 PM, confirmed that Resident #39 had not been showered or shaved and that today was the residents shower day. She revealed the resident should have been showered and shaved today.	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 610	Continued From page 33 Record review of Resident #39's ADL's revealed under," Reason not bathed dated 5/22/23 and timed 11:45 AM" documentation recorded, "No." Record review of the Face Sheet revealed Resident #39 was admitted to the facility on 9/18/20 with diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and Unspecified Dementia. Record Review of Resident #39's MDS with an ARD of 5/19/23 revealed under section C a BIMS score of 9, which indicated resident is moderately cognitively impaired.	M 610		