STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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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F 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 requirements for participation in Medicare and Medicaid. The SA cited F550 related to resident rights, F609 related to the failure to report an allegation of abuse timely, F656 related to developing and implementing care plans, F677 involving activities of daily living care, F690 for catheter care, and F725 related to lack of sufficient staffing. The census at the time of the survey was 101 with a bed capacity of 105.	F 000		
F 550 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	F 550		7/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/16/2023

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F 550	Continued From page 1 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. §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, 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	F 550	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.	

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F 550	Continued From page 2 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." 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	F 550	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 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	

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F 550	Continued From page 3 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 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	F 550	F Tag 550 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 F Tag 550. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 550.	

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F 550	Continued From page 4	F 550		

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. 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

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F 550	Continued From page 5	F 550		

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 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

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F 550	Continued From page 6 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.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		7/12/23

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F 609	Continued From page 7 by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to report an incident of resident-on-resident abuse timely for one (1) of 21 residents sampled. Resident #65 Findings include: Record review of facility policy titled, "Incident Investigation and Reporting," dated 10/22, revealed, "Purpose: To provide guidance to the facility for investigation and reporting incidents of abuse, neglect, exploitation, misappropriation of property and/or other reportable incidents to (proper name of stage agency), Attorney General, local law enforcement, and others as required by state and federal requirements. To ensure reporting reasonable suspicion of crimes against a resident within prescribed timeframes ...3 .... The administrator shall report to the State Survey Agency and local law enforcement entities in which the facility is located, any allegation or reasonable suspicion of a crime against any resident. The administrator shall report not later than two (2) hours after forming the suspicion, if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not involve abuse or result in serious body injury ..." During a dining room observation on 5/21/23 at 4:50 PM, prior to meal service, the State Agency (SA) observed approximately 20 residents in the dining room waiting for their evening meal. The State Agency observed a resident swing his right arm and his right-hand contacted Resident #65's left cheek. Resident #65 stated, "Dammit, you hit	F 609	The allegation of abuse, resident on resident altercation involving resident # 65 occurred on 5/21/23 at 4:50 pm and was reported to the State Agency on 5/22/23 at 2:28 pm by the Administrator. The Administrator was in-serviced on reporting allegations of abuse timely (no later than 2 hours of knowledge of allegation) by the Quality Improvement Nurse 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 reporting any allegation of abuse to the Administrator or Director of Nursing immediately, Resident Abuse, Elder Justice Act and Incident Investigation and Reporting 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 this deficient practice does not reoccur. Beginning 6/12/23, in the Daily Stand-Up Meeting, the Administrator or Director of Nursing will review all resident incident reports and grievances (ongoing review) to ensure any allegations have been reported per facility policy. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding F Tag 609 in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning	

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F 609	Continued From page 8 me" and attempted to propel herself in her wheelchair away from the other resident. There were no staff members present in the dining room at the time of this incident. SA immediately notified the first available staff member, Licensed Practical Nurse (LPN) #1, and she entered the dining room and separated the residents. The SA immediately notified the Administrator and the Director of Nursing (DON) of the incident. An interview with the Administrator on 5/22/23 at 3:10 PM, revealed Resident #65 was slapped on her face by another resident in the dining area. She confirmed she called this incident of resident-on-resident abuse into the State Agency today at 2:28 PM, therefore, she confirmed that she failed to notify the SA within the required two-hour time frame for an abuse allegation. She stated that the investigation is ongoing, and the final report will be submitted when completed. An interview with the Corporate Nurse on 5/24/23 at 3:20 PM, revealed the facility had begun the investigation and will submit the findings of this ongoing investigation when completed. Record review of Facility Suspected Crime Report Under Elder Justice Act form revealed the incident was reported to the State Survey Agency on 5/22/23 at 2:28 PM. This form also revealed this incident was reported to the Local Law Enforcement on 5/22/23 at 2:25 PM. Record review of the email dated 5/24/23 at 8:32 AM, revealed incident notification was sent to the Facility Reported Incidents division of the State Agency. Record review of Abuse, Neglect, and	F 609	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 F Tag 609. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 609.	

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F 609	Continued From page 9 Exploitation Complaint Online Form dated 5/22/23 at 3:32 PM, revealed the incident was reported to the Attorney General's office.Record review of email to the facility from the Attorney General's office revealed the confirmation of the submission of the incident. Record review of Resident #65's Face Sheet revealed she was admitted to the facility on 9/15/22. Diagnoses included Alzheimer's Disease, Dementia, Anxiety Disorder, and Depression. Record review of Resident #65's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/8/23 revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment.	F 609		
F 656 SS=G	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	F 656		7/12/23

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F 656	Continued From page 10 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: Based on observation, staff interviews, record review, and facility policy review, the facility failed to develop and implement a comprehensive care plan for a resident with a urinary catheter and for residents with Activities of Daily Living (ADL) that required oral care, nail care, bathing, and facial grooming for two (2) or twenty-one residents sampled. Resident #5 and Resident #85 Findings include:	F 656	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 # 85 received nail care to include trimming and cleaning and facial	

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F 656	Continued From page 11 A review of the facility's "Care Plan Process" policy, dated 06/15 with a revision date of 08/17, revealed, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). Resident #5 Record review of care plan revealed a care plan that resident required extensive staff assistance for activities of daily living. Interventions included oral care two times a day and as needed. Interventions also included to brush teeth each night after eating, and to swab gums with peri guard mouth rinse. 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, 5/13/23. 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	F 656	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 developing and implementing a comprehensive care plan to address residents with urinary catheters and residents that require assist with Activities of Daily Living to include oral care, nail care, bathing and facial grooming 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 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 on five residents to ensure that the comprehensive care plan is being followed regarding urinary catheters and Activities of Daily Living to include oral care, nail care, bathing and facial grooming three times weekly for four weeks, then monthly for four months. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding F Tag 656 in the Department Head Meeting weekly for four weeks then monthly for three months. Beginning 7/11/23, the Administrator or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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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F 656	Continued From page 12 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 the dependent resident's oral health. She confirmed the facility failed to ensure the resident received oral hygiene. 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 the care plan is a guide for the needed care for each resident and Resident #5's care plan was not followed. Record review of Electronic Medication Administration Record revealed the resident did not receive the ordered brushing of teeth or mouth rinse on 5/13/23. 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." Resident #85 A record review of Resident #85's Comprehensive Care Plan with Problem Onset: dated 08/12/2022 revealed, "Problem: Resident needs extensive assistance with ADLS-Limited ROM, Weakness, Poor Safety Awareness... Approaches... Prefers to keep a shaved face,	F 656	Director of Nursing will report any concerns at the Quality Assurance Committee Meeting, then monthly for three months until substantial compliance is achieved with F Tag 656. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 656.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	05/24/2023

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F 656	Continued From page 13 combed/brushed hair, and a haircut. Prefers to keep nails kept cut short..." Observation on 05/22/23 at 11:39 AM, revealed Resident #85 sitting in his wheelchair with bilateral fingernails that were approximately (approx) one half (1/2) inch long and jagged past the tip of fingers, a brown substance under each nail. Facial hair to cheeks, chin and above the residents' lip was approximately 1/2 inch long. An observation and interview on 05/22/23 at 4:10 PM, Resident #85 sitting in the dining room in his wheelchair. The Director of Nurses (DON) confirmed that he needed to be shaved. She confirmed his nails were long and jagged with a brown substance underneath and stated he could cut himself and he could get an infection if his nails were not taken care of. An interview on 05/24/23 at 11:05 AM, the Minimum Data Set (MDS) nurse revealed she is responsible for developing the care plans. She revealed the care plans are developed so the staff will know how to take care of the resident and the care plan should be so clear that anyone would know exactly how to take care of that resident to include that resident's preferences. An interview on 05/24/23 at 2:40 PM, the DON confirmed that the ADL care plan was not followed on Monday 5/22/23 in reference to Resident #85 being shaved and his nails being clean and trimmed.	F 656		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	05/24/2023

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TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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F 677	Continued From page 14 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on 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." 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"	F 677	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 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.	

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	255218	A. BUILDING _____ B. WING _____	05/24/2023

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F 677	Continued From page 15 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. 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	F 677	Beginning 6/13/23, the Director of Nursing or Staff Development Nurse will make rounds on five residents to ensure that 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 three months. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding F Tag 677 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 F Tag 677. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 677.	

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	255218	A. BUILDING _____ B. WING _____	05/24/2023

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F 677	Continued From page 16	F 677		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	05/24/2023

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F 677	Continued From page 17	F 677		

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 the resident was admitted to the facility on 10/21/2014 with diagnoses that included Alzheimer's Disease, Dementia, Anxiety Disorder, and Depression.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 18	F 677		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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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F 677	Continued From page 19	F 677		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	05/24/2023

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TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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F 677	Continued From page 20	F 677		

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.

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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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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F 677	Continued From page 21 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.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 690	Continued From page 22 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review the facility failed to ensure a resident with an indwelling catheter received the appropriate care and services to prevent Urinary Tract Infections (UTIs) to the extent possible for one (1) of nine (9) residents observed with an indwelling catheter. Resident #244 Findings include: Record review of the facility policy titled, "Urinary Catheter" with a revision date of 10/21 revealed, "... 24. Secure indwelling catheter with catheter strap or other securement device. b. Male i. Secure catheter tubing to upper thigh or lower abdomen." During an observation and interview with Licensed Practical Nurse (LPN) #1 on 05/21/23 at 6:05 PM, she confirmed that Resident #244 did not have a leg strap on to properly secure the catheter tubing and revealed it could cause a pull to his catheter and cause him problems, such as dislodgement or bladder spasms.	F 690	Resident # 244 urinary drainage bag was covered with a privacy bag and a urinary stabilization device was put into place to properly secure the catheter tubing on 5/21/23. All residents with indwelling catheters 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 the Urinary Catheter policy on 6/13/23 by the Director of Nursing. On 6/13/23 the Electronic Medication Administration Record was modified to include specific documentation for a catheter privacy bag and catheter tubing stabilization device placement for all residents with an indwelling catheter. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 690	Continued From page 23 An observation and interview on 05/21/23 at 6:20 PM, the Director of Nurses (DON) confirmed every resident that has a catheter must have a leg strap to prevent the urinary catheter from being pulled out and causing dislodgement or bladder spasms and confirmed that she would take care of that right away. A record review of Resident #244's Face Sheet revealed the resident was admitted to the facility on 5/04/23 with diagnoses of Encephalopathy, Unspecified injury of urethra, Unspecified injury of prostate, Weakness, Need for assistance with personal care, Benign Prostatic Hyperplasia with lower urinary tract. Record review of the Minimum Data Set (MDS) with an Advanced Reference Date (ARD) of 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.	F 690	Beginning 5/22/23, The Director of Nursing or Staff Development Nurse will check all residents with indwelling catheters to ensure a catheter privacy bag and a urinary tubing stabilization device is in place weekly for four weeks, then monthly for three months. Beginning 6/12/23, the Administrator or Director of Nursing will report any concerns regarding F Tag 690 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 F Tag 690. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 690.	
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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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F 725	Continued From page 24 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT 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 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	F 725	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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 25 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 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	F 725	6/13/23, Office Personnel who are licensed or certified were informed of requirement to assist with covering a call-in if needed 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 F Tag 725 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 F Tag 725. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 725.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 26	F 725		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 27	F 725		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 28	F 725		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 29	F 725		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 30	F 725		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 31	F 725		

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 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	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) COMPLETION DATE
F 725	Continued From page 32 highlighting a total number of 17 residents, which require staff assistance to be fed.	F 725		