

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER TISHOMINGO MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 230 KHAKI STREET , IUKA, Mississippi, 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	
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with two (2) Complaint Investigations (CI MS #3070317 and CI MS #3074482) at the facility from 07/20/26 through 07/23/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies F567, F607, F620, F641, F656, F688, F761, and F842. The SA investigated CI MS #3070317 and CI MS #3074482 and no deficiencies were cited. The census at the time of the survey was 101 and facility was licensed for 105 beds.		F0000				
F0567 SS = E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10)(i)(ii) \$483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund.		F0567				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0567 SS = E	Continued from page 1 (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is NOT MET as evidenced by: Based on resident interviews, staff interviews and resident representative interviews, record review, and facility policy review, the facility failed to safeguard and properly manage personal funds for two (2) of four (4) residents reviewed. The facility had withdrawn from residents personal-needs funds to pay past-due facility balances without demonstrating that the residents, or individuals possessing legal financial authority, specifically authorized the withdrawals before they occurred. Resident #2 and Resident #84 Findings include: Review of the facility policy titled "General Resident Trust Fund Policies," revised 1/20, revealed under "Basic Requirements: Residents have the right to manage their financial affairs.... The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds deposited with the facility..." Resident #2 Record review of Resident #2's "Resident Statement" revealed the facility made the following withdrawals from his trust-fund account, leaving him without his allotted \$44.00 monthly personal-needs allowance after his room and board were paid: On 11/06/23, the facility withdrew \$1,134.00, identified on the account statement as "Care Cost Payment." The withdrawal reduced the resident's account balance to zero and did not leave Resident #2's \$44.00 personal-needs allowance. On 09/04/24, the facility made two withdrawals totaling \$2,767.09. The facility withdrew \$1,470.09, identified as "RM BRD PAST DUE BALANCE" for August, and \$1,297.00, identified as "Care Cost Payment." The withdrawals reduced the resident's			F0567			

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F0567 SS = E	Continued from page 2 account balance to zero and did not leave Resident #2's \$44.00 personal-needs allowance. On 10/03/24, the facility withdrew \$1,340.00, identified as "Care Cost Payment." The withdrawal reduced the resident's account balance to zero and did not leave Resident #2's \$44.00 personal-needs allowance. On 11/05/24, the facility withdrew \$1,340.00, identified as "Care Cost Payment." The withdrawal reduced the resident's account balance to zero and did not leave Resident #2's \$44.00 personal-needs allowance. Record review revealed an untitled letter with a signature date of 01/16/25 that read, "I, (Resident #2) was denied Medicaid in August 2023 due to funds being deposited and withdrawn from my personal account. I owed the facility over \$25,000 due to being penalized for 3 months. I agreed to have my Social Security check direct deposited in the resident trust fund at (proper name of the facility). I also agreed to (proper name of the facility) applying my \$44.00 to the past due balance owed to the facility." The resident and the facility Accounts Manager signed the letter on 1/16/25, after the facility had made the identified withdrawals. An interview with the Administrator (ADM) on 7/21/26 at 4:04 PM revealed Resident #2 had a trust-fund account with the facility. The ADM stated she did not know whether the resident or the RR (resident representative) signed anything authorizing the facility to remove personal funds from the account. She revealed she thought the debt was written off by the corporate office. Record review of Resident #2's "Transaction Report" revealed the facility wrote off \$22,633.14 in bad debt on 10/31/24. During an interview on 7/21/26 at 4:52 PM, the Regional Vice President (VP) was asked why the resident was asked to sign the 1/16/25 agreement after the debt had been withdrawn and after the debt had been written off by the corporate office. The VP stated, "I get it, I understand, but I can't answer that". An interview with Resident #2 on 7/22/26 at 7:30 AM revealed he did not recall whether staff spoke with him about the debt or whether he signed an agreement allowing the facility to apply his personal funds to the facility balance.	F0567					

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F0567 SS = E	Continued from page 3 An interview with the Accounts Manager on 7/22/26 at 7:39 AM revealed the facility deducted the resident's \$44.00 personal-needs allowance toward the outstanding balance before she assumed the position. The Accounts Manager stated a Medicaid auditor told the facility that they could not take the resident's \$44.00 without his permission. She confirmed that she drafted the 1/16/25 agreement after the deductions occurred and after the debt was written off. The Accounts Manager stated, "I got the resident to sign the agreement to cover the time that the facility was deducting the 44 dollars before I had the job." A telephone interview with Resident #2's RR on 7/23/26 at 12:01 PM revealed she did not recall the facility notifying her that it intended to collect money from Resident #2's trust-fund account to pay the past-due balance. She confirmed she never authorized the transactions and did not have legal authority to make his financial decisions. Record review of Resident #2's "Admission Agreement," dated 2/07/22, revealed under "Section C. The resident and/or resident representative agree: ...3. To be responsible for all other services/charges in relation to the resident's care, when these services/charges are not mandated as covered services to be provided by the Facility..." The RR signed the agreement on 2/7/22. The agreement did not specifically authorize the facility to withdraw Resident #2's personal-needs funds to satisfy a past-due facility balance. Further review of the "Admission Agreement" on page 9, indicated Resident #2 did not have a Power of Attorney, Conservator, or Health Care Surrogate. The facility did not provide an agreement, authorization, receipt, progress note, or other contemporaneous documentation showing Resident #2 authorized the facility to apply his \$44.00 personal-needs allowance toward the outstanding facility balance before the withdrawals occurred. Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 2/7/22 with medical diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/22/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 in Section C, indicating Resident #2 was cognitively intact.	F0567					

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F0567 SS = E	Continued from page 4 Resident #84 Record review of Resident #84's Medicaid liability notice dated 5/21/24 revealed that, effective 7/01/24, the resident's Medicaid-established monthly liability was \$1,545.00. Record review of Resident #84's trust-fund "Resident Statement" revealed the facility reduced or eliminated the resident's available \$44.00 personal-needs funds to pay a past-due facility balance, as follows: On 8/05/24, following an 8/02/24 SSA (Social Security Administration) deposit of \$1,589.00 and an existing trust-fund balance of \$4.40, the facility withdrew \$234.94, identified as "RM BRD JULY," and \$1,358.46, identified as "Care Cost Payment," totaling \$1,593.40. The withdrawals reduced Resident #84's trust-fund account balance to \$0.02. On 9/04/24, the facility withdrew "Past Due Balance" amounts of \$186.54 and \$1,402.47, totaling \$1,589.01. The total withdrawn was \$44.01 more than Resident #84's Medicaid-established monthly liability and reduced the resident's trust-fund account balance to \$0.00. On 10/03/24, the facility withdrew \$1,545.00, identified as "Care Cost Payment," followed by \$20.01, identified as "Payment on Past Due." The additional \$20.01 withdrawal reduced Resident #84's available personal-needs funds from \$44.01 to \$24.00. On 11/05/24, the facility withdrew \$1,583.00, identified as "Care Cost Payment." This amount exceeded the \$1,545.00 monthly liability identified in the Medicaid notice by \$38.00 and left \$10.00 in the resident's trust-fund account. On 12/03/24, the facility withdrew \$1,575.01, identified as "Care Cost Payment." This amount exceeded the \$1,545.00 monthly liability identified in the Medicaid notice by \$30.01 and left \$24.00 in the resident's trust-fund account. From 9/04/24 through 12/03/24, the facility withdrew at least \$132.03 more than Resident #84's Medicaid-established monthly liability. The 9/04/24 and 10/03/24 ledger entries specifically identified additional withdrawals as payments toward the resident's "Past Due Balance." Further review of Resident #84's trust-fund "Resident Statement" revealed the facility continued	F0567					

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F0567 SS = E	Continued from page 5 to withdraw personal-needs funds for past-due facility debt during 2025. On 2/03/25, the facility withdrew \$1,584.00, identified as "Care Costs Payment," leaving \$44.00 in the resident's trust-fund account. The facility then withdrew an additional \$20.00, identified as "Towards Past Due," reducing the resident's available personal-needs funds to \$24.00. On 3/03/25, the facility withdrew \$18.96, identified as "RM and BED FEB 2025," followed by \$1,584.00, identified as "Care Cost Payment." The separately identified "RM and BED FEB 2025" withdrawal was applied to a prior-month facility bill and reduced the resident's available trust-fund balance to \$29.05. Record review of Resident #84's "General Notes Report" revealed an entry dated 8/02/24 under "Financial," which documented, "Spoke with RP (responsible party) on 8/02/24. She said she has no money to pay the past due amount owed for May 2024, and for us to take the \$44.00 each month until it is paid in full." A second entry dated 1/06/25 documented, "Resident pays an extra \$20.00 each month towards past due amount." During an interview on 7/23/26 at 11:00 AM, Resident #84 was asked whether he authorized the facility to withdraw funds from his trust-fund account to pay a past-due facility balance. Resident #84 stated, "If they talked to me, I gave them permission but didn't sign anything." Resident #84 did not confirm that facility staff spoke with him and could not identify the amount, frequency, or duration of any withdrawals he authorized. During a telephone interview on 7/23/26 at 11:27 AM, Resident #84's Resident Representative (RR) stated the facility contacted her about an outstanding balance. She stated a staff member told her she could pay the balance or the facility could withdraw money from Resident #84's facility account. The RR stated she agreed to the withdrawals because she believed Resident #84 might lose his placement if the balance remained unpaid. She stated she was given two options: she could pay the bill, or the facility could deduct the money from Resident #84's account. The RR stated she was a stay-at-home mother and did not have the money to pay the bill. She stated Resident #84 was unhappy because the withdrawals left him without money to purchase personal items. Record review of Resident #84's "Admission Agreement," dated 6/01/23, revealed under			F0567			

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F0567 SS = E	Continued from page 6 "Admission Acknowledgements and Authorizations" no documentation that Resident #84 had a power of attorney, conservatorship, or other individual with legal financial authority. During an interview on 7/23/26 at 2:28 PM, the Administrator (ADM) stated the facility never withdrew money from a resident's trust account without the resident's consent. The ADM confirmed the facility withdrew Resident #84's funds to pay past-due balances but stated the facility never took the full \$44.00 and withdrew only \$20.00. During an interview on 7/23/26 at 2:58 PM, the Accounts Manager stated she spoke with the RR and Resident #84's son in an effort to collect the resident's outstanding balance. The Accounts Manager stated she then contacted the RR, who said she could not afford to pay the balance and told her to take the resident's \$44.00. The Accounts Manager stated, "I only took out \$20.00." When asked whether she obtained Resident #84's signature authorizing the facility to collect the outstanding balance from his trust-fund account, she stated, "We could not find it; I'm not sure if he signed one or after our last Medicaid audit it got shredded." The Accounts Manager stated Resident #84 agreed to the withdrawals; however, the facility was unable to provide written documentation showing the resident authorized withdrawals from his trust-fund account to pay the past-due facility balance. Although the Administrator and Accounts Manager stated the facility withdrew only \$20.00 monthly, the trust-fund statements showed withdrawals that reduced Resident #84's available personal-needs funds by as much as \$44.01. The facility did not provide documentation showing Resident #84 authorized the withdrawals or that the RR had legal authority to authorize the use of the cognitively intact resident's personal funds. Record review of the "Face Sheet" revealed the facility admitted Resident #84 on 6/01/23 with medical diagnoses including Unilateral Primary Osteoarthritis, Left Knee. Record review of the MDS, with an ARD of 7/08/26, revealed in Section C a BIMS summary score of 15, indicating Resident #84 was cognitively intact.	F0567					
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F0607					

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F0607 SS = D	Continued from page 7 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to implement their facility policy for reporting an alleged allegation of misappropriation of resident funds to the appropriate agencies for one (1) of four (4) residents reviewed for allegations of misappropriation. Resident #2 Findings Include: Record review of the facility policy titled "Incident investigation & (and) Reporting" revised 5/24, revealed under, "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 MSDH (Mississippi State Department of Health), Attorney General, local law enforcement, and others as required by state and federal requirements..."	F0607					

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F0607 SS = D	Continued from page 8 An interview with the Regional Vice President (VP) on 7/20/26 at 4:27 PM revealed when Resident #2 came up for Medicaid redetermination his Resident Representative (RR) failed to take in the requested financial documents to the Medicaid office and he was penalized for three (3) months, September, October, and November 2023. Record review of the email communication regarding Resident #2 between the State Medicaid Agency and the Facility Accounts Manager, dated 9/19/24 revealed, "He had someone giving him money and also someone was using his card and making large purchases and withdrawals." Follow up interview with the Regional VP on 7/21/26 at 4:52 PM revealed the facility did not notify any other outside agencies or notify the Attorney General (AG) office when they were made aware of the large money transfer in and out of Resident #2's bank account. An interview with Resident #2 on 7/22/26 at 7:30 AM revealed that he did not recall having a personal bank account and only recalls having an account with the facility. An interview with the Accounts Manager on 7/22/26 at 9:03 AM revealed that Resident #2 came up for Medicaid redetermination and during that time he was having thousands of dollars of money going in and out of his personal bank account. She revealed that the State Medicaid Agency notified her via email that someone had the residents debit card and was going haywire with it. She stated she knew what misappropriation was, but the account was his personal account, and the facility did not have access to it. The Accounts Manager confirmed she did notify the Administrator when she was made aware that someone was utilizing his personal funds, and he had been denied Medicaid during his recent period. An interview with the Administrator (ADM) on 7/22/26 at 10:00 AM revealed, "I do remember the communication with the State Medicaid Agency that someone was using his debit card and making large transactions from his account." When inquired if the facility had an obligation and a duty to report misappropriation of any kind she stated, "I probably should have." She revealed she was the abuse coordinator, but she thought the State Medicaid Agency would handle it. A follow up interview with the ADM on 7/23/26 at	F0607					

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F0607 SS = D	Continued from page 9 8:02 AM revealed if someone was using Resident #2's debit card he had to have given it to them and gave permission. She stated the resident was cognitive and she acknowledged she never had a discussion with the resident regarding the transactions to ensure he authorized it. Record review of the "Face Sheet" revealed Resident #2 was admitted to the facility on 2/7/22 with diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/22/26, revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #2 was cognitively intact.	F0607					
F0620 SS = D	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.	F0620					

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F0620 SS = D	Continued from page 10 §483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative (RR) and staff	F0620					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0620 SS = D	Continued from page 11 interview, record review, and facility policy review, the facility failed to ensure it did not request or require third-party guarantees of payment by holding RR's personally responsible for residents' facility charges for two (2) of 2 residents reviewed for admission and financial agreements. Resident #2 and Resident #84 Findings Include: Record Review of the facility policy titled "A/R (Accounts Receivable) Type – Private Pay" revised 9/24, Revealed under, "Collection Policy: Payment is expected by the 5th of the month and the is considered past due on the 10th. If payment is not received by the 10th, the administrator should contact the resident representative by telephone or in person. If payment is not received by the 15th, a copy of this statement should be stamped "Past Due" and mailed to the resident representative. The administrator should contact the resident representative by phone or in person again. If payment is not received by the 20th, a final statement should be mailed to the resident representative. The need to continue collection efforts beyond this point will follow the bad debt procedure outlined in this manual." Resident #2 Record review of a "Debt Collection Letter" dated 8/23/2024, addressed to Resident #2's RR revealed the facility sought payment from the RR. The letter stated, "Despite our previous reminders, the amount due remains unpaid. As such, we would appreciate you making this payment as soon as possible. AMOUNT DUE: \$27,989.85...We regret to advise that unless payment is received within 14 days of this letter this account will be turned over to an attorney for collection and the account is subject to interest and attorney fees..." Record review of Resident #2's "Debt Collection Letter," dated 9/16/24, and addressed to the RR revealed the facility sought payment of \$25,054.05 from the RR. Record review of the "Facility Bad Debt Declaration," dated 10/25/24, revealed "Resident/Family refuses to pay" was checked as the reason for the bad debt. The declaration stated Resident #2 was penalized for August, September, and October 2023 after Medicaid denied coverage. Record review of Resident #2's "Admission Agreement," dated 2/07/22, revealed under "Section	F0620					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0620 SS = D	Continued from page 12 C. The resident and/or resident representative agree: ...3. To be responsible for all other services/charges in relation to the resident's care, when these services/charges are not mandated as covered services to be provided by the Facility..." The RP signed the agreement on 2/7/22 and had no legal authority to access the residents' funds. Record review of the "Face Sheet" revealed Resident #2 was admitted to the facility on 2/7/22 with a diagnosis of Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/22/26, revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #2 was cognitively intact. Resident #84 Record review of Resident #84's "Debt Collection Letter," dated 7/19/24 and mailed to the RR, revealed, "We regret to advise that unless payment is received in 14 days of this letter this account will be turned over to an attorney for collection and the account is subject to interest fees." The Administrator signed the letter, which identified an outstanding balance of \$234.94. Record review of Resident #84's "Admission Agreement," dated 6/01/23, revealed under "Section C. The resident and/or resident representative agree: ...3. To be responsible for all other services/charges in relation to the resident's care, when these services/charges are not mandated as covered services to be provided by the Facility..." The RR signed the agreement on 6/1/23 and had no legal authority to access the residents' funds. On 7/23/26 at 11:27 AM, during a telephone interview with Resident #84's RR she stated the facility contacted her about an outstanding balance. She revealed that facility staff explained that Medicaid and Medicare paid a certain amount, and that Resident #84 had a remaining balance at the end of the year. She stated, "They told me I was responsible for the bill." The RR stated the balance was more than \$200.00 and a staff member told her she could either pay the balance or the facility would withdraw the money from Resident #84's facility account. She stated, "I am a stay-at-home mother; It's just me and my sister and we do not have the extra money to pay his bills." Record review of Resident #84's "General Notes	F0620					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0620 SS = D	Continued from page 13 Report" revealed an entry dated 8/02/24 under "Financial," which documented, "Spoke with RP (responsible party) on 8/02/24. She said she has no money to pay the past due amount owed for May 2024, and for us to take the \$44.00 each month until it is paid in full." An interview with the Accounts Manager on 7/22/26 at 7:39 AM stated that, when an RR signed the admission agreement, the RR assumed responsibility for charges incurred by the resident. When asked whether this depended on the RR having legal authority to access the resident's funds, she stated, "It does not matter, it is part of their responsibility." She confirmed this was a facility practice of debt collection. During an interview on 7/23/26 at 1:44 PM, Social Services (SS) revealed she had a lot of family members who will not sign to be a RR because of verbiage in the admission agreement making them responsible for the residents' debts. She confirmed the agreement required the family to pay and did not state if they had legal authority and it must be from the resident's account. During an interview on 7/23/26 at 2:28 PM, the Administrator (ADM) stated the facility was a business and had to collect outstanding balances confirming the facility considered RR's responsible for resident's account balances. Record review of Resident #84's "Face Sheet" revealed the facility admitted him on 6/01/23 with a medical diagnosis of Unilateral Primary Osteoarthritis of the Left Knee. Record review of the MDS with an ARD of 7/08/26 revealed under section C a BIMS summary score of 15, indicating Resident #84 was cognitively intact.			F0620			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.			F0641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0641 SS = D	Continued from page 14 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) to reflect a State Level II Preadmission Screening and Resident Review (PASRR) determination of serious mental illness for one (1) of 23 residents reviewed for MDS accuracy. Resident #2 Findings include: Review of the facility policy titled "MDS Charting Documentation Guidelines," revised 11/25, revealed, "...To have an accurate assessment of the residents, information must be gathered on the residents while in the observation period for the MDS. This information must come from resident assessment and documented information in the residents' chart within the times frames set forth on the MDS..." Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 2/7/22 with a medical diagnosis of Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular disease. Record review of the "Preadmission Screening and Resident Review (PASRR)," dated 2/17/22, revealed,	F0641					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0641 SS = D	Continued from page 15 "Summary of Findings Report: The individual meets criteria for mental illness as defined by PASRR." The report identified schizophrenia as Resident #2's qualifying mental illness. Record review of the Significant Change MDS with an Assessment Reference Date (ARD) of 3/27/26 revealed that Section A1500 asked, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?" The facility coded "No." During an interview on 7/23/26 at 9:42 AM, the MDS Nurse confirmed Resident #2 had received a Level II PASRR determination. She stated she did not code the determination on the MDS because Resident #2 refused mental health services. The MDS Nurse acknowledged that the resident's refusal of services did not change the Level II PASRR determination and confirmed Section A1500 should have been coded to reflect the determination. She stated the assessment should be accurate so the plan of care could be developed. Record review of the MDS with an ARD of 6/22/26 revealed a Brief Interview for Mental Status (BIMS) summary score of 15 in Section C, indicating Resident #2 was cognitively intact.	F0641					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F0656					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER TISHOMINGO MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 230 KHAKI STREET , IUKA, Mississippi, 38852			
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F0656 SS = D	Continued from page 16 (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 interview, record review, and facility policy review the facility failed to implement a comprehensive care plan for one (1) of 23 sampled residents, Resident #6. Findings Include: Review of the facility policy "Care Plan Process" with revision date of 12/24 revealed, "...The facility must develop a comprehensive care plan for each resident.... The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being... The facility staff shall follow the care plan..." Record review of Resident #6's care plan with an initiated date of 03/04/2025, revealed, "Range of motion (ROM) (active and passive) with am/pm care daily as needed." Record review of Resident #6's "Documentation Survey Report" task revealed no order to perform range-of-motion exercises. On 07/22/26 at 9:45 AM an interview with Physical Therapy Assistant (PTA) #1, revealed that Resident #6 received Occupational Therapy (OT) Services and was discharged to the Restorative Nursing Program	F0656					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0656 SS = D	Continued from page 17 (RNP) on 12/30/25. On 07/22/26 at 11:15 AM during an interview and record review with the Restorative Nurse, she confirmed that Resident #6 was not enrolled in the Restorative Nursing Program despite being referred by the therapy department. She further acknowledged that active and passive ROM interventions had not been assigned under the restorative task tab nor under the task for any other Certified Nursing Aid (CNA) to complete. Restorative Nurse reviewed Resident #6's "Task" and confirmed that there was no documentation to reflect that ROM exercises were being completed, and she confirmed that a care plan for Restorative Nursing was not implemented. During this interview, Restorative Nurse also acknowledged that active and passive ROM daily interventions were included in the resident's care plan and stated, "I agree 100% that since range of motion exercises were on the care plan, they should be completed." She further acknowledged that the facility was aware that therapy referrals continued to be generated while the restorative program was not fully operational and stated the referrals should have been reviewed to ensure the ordered interventions were implemented. An interview on 07/23/26 at 11:05 AM with Minimum Data Set (MDS) Nurse revealed that the purpose of the care plan is to make sure every resident receives the care they need based on their individual needs, goals, and preferences. She revealed that it tells the staff what care to provide and how to provide it. MDS Nurse reviewed Resident #6's Care Plan and confirmed that the intervention for range of motion was included in the care plan and should have been followed. Record review of Resident #6's "Face Sheet" revealed an admission date of 03/04/25 with diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of Resident #6's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/02/26 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated she had severe cognitive deficits.	F0656					
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition	F0688					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0688 SS = D	Continued from page 18 demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure range of motion services were implemented in accordance with therapy recommendations and resident care needs for two (2) of four (4) residents reviewed (Residents #2 and #6). Residents discharged from therapy to the Restorative Nursing Program were not enrolled, evaluated, assigned restorative tasks, or provided ordered active/passive range of motion interventions. Findings include: Review of the facility policy, "Range of Motion" with revision date of 01/24 revealed under the "Purpose" revealed "To move the resident's joints through as full a range of motion as possible. To improve or maintain joint mobility and muscle strength. To prevent contractures. To increase strength and activity tolerance. To reduce pain. To prevent complications of mobility..." Resident #2 An observation and interview on 7/20/26 at 1:46 PM revealed Resident #2 lying in bed. He stated he had left-sided hemiparesis and a contracture of the fingers on his left hand. He explained that he had been off therapy for a while and nobody performed exercises with his extremities. The resident stated he was supposed to have a hand device, but he could not keep track of it and did not know where it was. The fingers on his left hand were bent inward toward his palm. Record review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/22/26, revealed that Section GG	F0688					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0688 SS = D	Continued from page 19 Functional Limitations in Range of Motion documented upper and lower extremity functional limitations on both sides. Record review of Resident #2's "Occupation Therapy (OT) Discharge Summary" dated 4/28/25 revealed, "Pt (patient) discharging from skilled OT services to RNP (Restorative Nursing Program) and LTC (Long Term Care) Pt has left hand carrot to be used to continue to maintain joint motility and skin integrity." Also revealed under, "Notes: Staff educated on wear schedule for up to 4 (four) hours at this time. To be removed and skin integrity checked every 2 hours for edema and redness." Record review of Resident #2's July 2026 "Documentation Survey Report" task revealed there was no order to perform range-of-motion exercises or apply a carrot splint to the resident's left hand. An interview with the Restorative Certified Nurse Aide (CNA) on 7/21/26 at 2:44 PM revealed passive range of motion was not included in the resident's tasks for the aides to perform. She stated only residents enrolled in the restorative program received range-of-motion exercises and that eight residents were currently enrolled. She confirmed Resident #2 did not have a carrot splint or have a task set up for them to apply the device. An interview with the Physical Therapy Assistant (PTA)#2 on 7/21/26 at 2:53 PM confirmed Resident #2 was discharged to the restorative nursing program on 4/28/25. The PTA stated the OT developed a restorative treatment plan that would have been provided to the staff development nurse for inclusion in the aides' daily care plan. An interview with Restorative Nurse on 7/21/26 at 3:04 PM revealed she had recently assumed the restorative nurse role. She stated that when a resident was referred to the restorative program, the restorative nurse would complete an evaluation. She confirmed she found no evidence that an evaluation was completed or that the OT recommendations were added to the resident's tasks for implementation. The Restorative Nurse acknowledged that failure to implement the services could cause the resident's contracture to worsen. Record review of the "Restorative Nursing Program Plan "dated 4/28/25, revealed under, "Range of Motion... Pt (patient) to perform AROM (active range of motion) of RUE (right upper extremity) in all planes of movements for digits, wrist, elbow, and shoulder to maintain joint mobility and skin	F0688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0688 SS = D	Continued from page 20 integrity...PROM (passive range of motion) to be performed before splinting of left and in all planes of movement for wrist, digits, elbow, and shoulder." Additionally revealed under "Splinting and/or bracing: Resident to complete Upper Extremity (UE) splinting/bracing program as tolerated up to 5 (five) hours, splint to be checked every 2 hours for skin integrity, edema, and redness..." Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 2/7/22 with a medical diagnosis of Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease. Record review of the MDS with an ARD of 6/22/26 revealed a Brief Interview for Mental Status (BIMS) summary score of 15 in Section C, indicating Resident #2 was cognitively intact. Resident #6 An interview on 07/22/26 at 9:45 AM with PTA #1, revealed that Resident #6 received OT Services and was discharged to the RNP on 12/30/25. During an interview on 07/22/26 at 11:15 AM with Restorative Nurse, she confirmed that Resident #6 was not enrolled in the Restorative Nursing Program despite being referred by the therapy department. She further acknowledged that active and passive Range of Motion (ROM) interventions had not been assigned under the restorative task tab nor under the task for any other Certified Nursing Assistant (CNA) to complete. She revealed that the Restorative Nursing Program was not fully operational when Resident #6 was last referred and stated that a custom task for range of motion exercises should have been created so that CNAs could identify, complete, and document the ordered care. Restorative Nurse reviewed Resident #6's "Task" and confirmed that there was no documentation to reflect that ROM exercises were being completed. She further revealed that therapy referrals continued to be generated while the Restorative Program was not fully operational and stated the referrals should have been reviewed to ensure the ordered care was provided. She also confirmed that failure to provide the prescribed ROM exercises could result in pain, decreased range of motion, and the development of contractures. An interview on 07/22/26 at 11:15 AM with			F0688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0688 SS = D	Continued from page 21 Restorative CNA, revealed that residents discharged from therapy services to the Restorative Nursing Program were expected to receive the ordered services. She verified that Resident #6 was not enrolled in the Restorative Nursing Program and confirmed that active and/or passive range of motion exercises were not included in Resident #6's assigned CNA tasks for completion and documentation. Record review of Resident #6's OT Discharge Summary dated 12/30/25 revealed that she was discharged from skilled OT services to LTC with RNP in place. Record review of Resident #6's "Face Sheet" revealed an admission date of 03/04/25 with diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of Resident #6's MDS with ARD of 07/02/26 under Section C revealed a BIMS Score of 03 which indicated she had severe cognitive deficits. Record review of Resident #6's Comprehensive MDS under Section GG "Functional Limitation in Range of Motion" revealed that she had functional impairment to upper and lower extremities on one side. Record review of Resident #6's "Care Plan Report" revealed that she has right sided hemiplegia/hemiparesis stroke and had an intervention initiated on 03/04/25 to have range of motion (active or passive) with am/pm care daily as needed. Record review of Resident #6's July 2026 "Documentation Survey Report" task revealed there was no order to perform range-of-motion exercises.			F0688			
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate			F0761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0761 SS = D	Continued from page 22 accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure medication labeling was accurate for one (1) of 26 medication opportunities and failed to ensure medications were properly stored for one (1) of 101 residents. Resident #24 and Resident #71 Findings include: Review of facility policy titled "Monitoring Medication Pass" with review date 12/20, revealed, "...11. No medications left at bedside..." Review of the facility's "Drug Administration and Documentation" policy, with a revision date of 03/25, revealed "...Read the medication label and compare it with the Medication Administration Record (MAR)..." Resident #24 During an observation and interview on 7/20/2026 at 10:29 AM, it was revealed there were two (2) medication cups with topical medications left in Resident #24's room. One (1) medication cup was half filled with a white creamy substance sitting on his dresser. The second medication cup was one-fourth filled with a cream/white powdery substance on Resident #24's nightstand. Resident #24 stated that he used that cream and powder to	F0761					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0761 SS = D	Continued from page 23 rub underneath his breast and on his bottom. During an interview on 7/20/2026 at 10:36 AM, Restorative Certified Nursing Assistant (CNA) confirmed the two medication cups in the room with a white creamy substance in one and a powdery substance in the other. She stated, "These are not supposed to be left in the room. Another resident could get it and possibly eat it." During an interview on 7/22/2026 at 3:45 PM and again on 7/23/2026 at 11:02 AM, the Director of Nursing (DON) confirmed that medication should not be left at the bedside and that any wandering resident could get it. She further stated, "All nurses have access to the treatment cart, so any nurse could have left it. They know better and we will do retraining on that tomorrow." Record review of the Face Sheet indicated Resident #24 was admitted to the facility on 6/8/2026 with medical diagnoses that included Cerebral Palsy, unspecified. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/15/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #24 was cognitively intact. Resident #71 During medication administration observation and record review on 07/22/2026 at 9:11 AM, an observation revealed a pharmacy label affixed to Resident #71's medication card identified the medication as Lasix 40 milligrams (mg). Record review of the electronic Medication Administration Record (eMAR) revealed the order dated 5/30/26 was entered as Lasix 20 mg, give 40 mg by mouth one time a day for edema of leg. The discrepancy between the medication label and the eMAR created the potential for a medication administration error. The resident refused the medication prior to administration; therefore, no medication was administered during the observation. On 07/22/2026 at 9:11 AM, during an interview with Licensed Practical Nurse (LPN) #4, she confirmed the medication label and the eMAR did not match and stated the order should have been changed in the computer to avoid a medication error and ensure the medication was labeled properly. She stated they did			F0761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0761 SS = D	Continued from page 24 send two 20 mg tablets and started sending 40 mg tablets recently. During an interview with Medical Records on 07/22/2026 at 9:32 AM, she confirmed the order was changed on 5/29/2026 and should have been changed to accurately reflect the physician's order and avoid the potential for medication administration error. Record review confirmed the pharmacy label and the eMAR were inconsistent. The medication card reflected a new order that was given on 5/29/2026 of Lasix 40 mg, while the eMAR displayed Lasix 20 mg, give 40 mg, creating the potential for a medication administration error. During an interview on 07/22/2026 at 10:00 AM with the Director of Nursing (DON), she stated the nurse who entered the order works as needed and may not have experience entering the order correctly. Record review of the Face Sheet revealed Resident #71 was admitted to the facility on 12/23/2025, with diagnoses including Cerebral Infarction. Record review of the MDS assessment with an ARD of 6/17/2026 revealed the resident had a BIMS score of 7, indicating severe cognitive impairment.	F0761					
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F0842					

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F0842 SS = D	Continued from page 25 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842					

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F0842 SS = D	Continued from page 26 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, and facility policy review, the facility failed to maintain complete and accurate clinical records for one (1) of 23 sampled residents Resident #18. Findings Include: Review of the facility's "Drug Administration and Documentation" policy, with a revision date of 3/25, the policy revealed "...The complete act of administration entails...promptly recording the time and dose given..." Review of the facility's "Procedure for Changing I.V. (Intravenous) Solution" policy, with an original date of 10/16, the policy states, "...8. Record in the resident's clinical record." Record review of the July 2026 Medication Administration Record (MAR) for Resident #18 revealed an order for Meropenem Solution Reconstituted 1 MG (gram) use one gram intravenously every 12 hours for bacterial infection..." Documentation was missing for four (4) of 20 scheduled intravenous Meropenem 1 gram administrations. Documentation was absent for the scheduled doses due on 7/11/2026 at 0900 (9:00 AM), 7/16/2026 at 0600 (6:00 AM), 7/17/2026 at 1800 (6:00 PM), and 7/19/2026 at 0600. Further record review of the July 2026 Treatment Administration Record (TAR) for Resident #18 revealed an order dated 12/24/25 "Clean suprapubic catheter site with NS (normal saline), pat dry, and apply split sponge daily". Multiple scheduled catheter care entries lacked documentation that the ordered care had been completed. The dates included 7/6/26, 7/8/26, 7/10/26, 7/13/26 through 7/16/26. During an interview with the Director of Nursing (DON) on 7/22/2026 at 10:10 AM, she revealed the nurse had forgotten to document the intravenous medication administrations due to the digital system rolling to the next shift. The DON confirmed	F0842					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0842 SS = D	Continued from page 27 intravenous medication administrations are to be documented on the Medication Administration Record (MAR) at the time they are administered as well as catheter care that was completed for Resident #18. During an interview with Resident #18 on 07/22/2026 at 3:30 PM, she revealed she believed she received every scheduled dose of her intravenous antibiotic and that staff routinely performed catheter care each shift. The resident did not recall staff skipping a day of her antibiotic therapy or catheter care. Record review of the Face Sheet revealed Resident #18 was admitted to the facility on 1/21/25, with diagnoses including chronic kidney disease. Record review of the Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of July 10, 2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.			F0842			