

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255101		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER MCCOMB COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 415 MARION AVE , MCCOMB, Mississippi, 39648			
(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 #3028896 and CI MS #3050974) at the facility from 8/3/26 through 8/6/26. The SA investigated CI MS # 3028896 for environment and activities of daily living. CI MS # 305974 was investigated for staffing. There were no citations related to the complaint investigations. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F684, F880, F677, and F867. The facility had a census of 101 and was licensed for 140 beds.		F0000				
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide		F0656				

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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F0656 SS = E	Continued from page 1 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 follow the comprehensive care plan for obtaining the physician-ordered Hemoglobin A1C laboratory test for two (2) of (21) sampled residents. Resident #43 and Resident #105. Findings include: A record review of the facility policy, "Care Plans, Comprehensive Person-Centered," revised March 2022, reveals, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...." Resident #105 A review of Resident #105's "Care Plan Report" initiated on 4/10/26, directed staff to monitor laboratory results, report results to the physician as needed, and obtain a hemoglobin A1C every three months during January, April, July, and October. A review of Resident #105's "Order Summary	F0656			

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F0656 SS = E	Continued from page 2 Report" revealed an order dated 4/8/26 to obtain a hemoglobin A1C every three months during January, April, July, and October. A review of Resident #105's "Admission Record" revealed the facility admitted the resident on 4/7/26 with diagnoses that included type 2 diabetes mellitus without complications and end-stage renal disease. a A review of Resident #105's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/08/26, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. A review of Resident #105's laboratory records revealed the hemoglobin A1C care planned for July 2026 was not completed. Resident #43 A review of Resident #43's "Care Plan Report", initiated on 7/16/24, directed staff to obtain laboratory tests as ordered. During an interview on 8/5/26 at 3:37 PM, the Director of Nursing (DON) acknowledged Resident #43's hemoglobin A1C was due in July 2026 and confirmed it was not completed as ordered and care planned. A review of Resident #43's "Admission Record" revealed the facility admitted the resident on 7/16/24 with diagnoses that included type 2 diabetes mellitus without complications, stage 3 chronic kidney disease, and paroxysmal atrial fibrillation. A review of Resident #43's Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 5/15/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #43's physician orders revealed an order to obtain a complete blood count (CBC), comprehensive metabolic panel (CMP), and hemoglobin A1C every three months during January, April, July, and October. A review of Resident #43's laboratory records revealed the CBC, CMP and hemoglobin A1C care planned for July 2026 were not completed. During an interview on 8/5/26 at 2:15 PM, the DON			F0656			

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F0656 SS = E	Continued from page 3 acknowledged Resident #105's hemoglobin A1C was due in July 2026 but was not completed. The DON stated the facility did not have a staff member specifically assigned to ensure laboratory tests were completed following a change to a new company. The DON stated nursing leadership was responsible for assigning and overseeing the completion of ordered laboratory tests. During an interview on 8/5/26 at 2:40 PM, Medical Records Licensed Practical Nurse (LPN) #1 stated her assigned duties included running a monthly report to identify laboratory tests due during the previous month. LPN #1 acknowledged she did not run the July report because she had been on vacation and had a heavy workload when she returned. LPN #1 stated timely completion of hemoglobin A1C testing allowed the provider to determine whether a resident's blood glucose was controlled. During an interview on 8/6/26 at 9:11 AM, LPN #2, the Care Plan Coordinator, stated the comprehensive care plan provided structure for how staff should meet each resident's care needs. LPN #2 stated the care plan included instructions for monitoring ordered laboratory tests and that staff should ensure the tests were completed as scheduled. LPN #2 stated failure to implement a resident's care plan could result in adverse outcomes and prevent staff from identifying changes in the resident's condition. During an interview on 8/6/26 at 12:44 PM, the Administrator stated she expected staff to complete laboratory tests according to physician orders because timely testing assisted with preventing negative health outcomes.	F0656			
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	F0684			

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F0684 SS = E	Continued from page 4 failed to obtain physician-ordered hemoglobin A1C laboratory tests for two (2) of (21) sampled Residents. Findings include: In an interview with the Director of Nursing (DON) on 8/5/26 at 2:15 PM, she acknowledged that Resident #105 has a doctor's order for Hemoglobin A1C labs scheduled for April, July, and October, but the July lab was not completed. She added that with the change to the new company, there were no staff members specifically assigned to ensure the labs were completed as ordered. The DON stated it is important to ensure labs are completed timely in order to identify if a resident has had a change in condition. When asked whose role it is to ensure labs are completed as scheduled, the DON indicates that nursing leadership is responsible for assigning and overseeing completion of ordered labs. In an interview with the Medical Records Licensed Practical Nurse (LPN) #1 on 8/5/26 at 2:40 PM, she acknowledged that it has been part of her role to run a monthly report at the end of each month to identify labs needed for the previous month. She states she did not run the July report because she was on vacation, and her workload was very full when she returned. She added that she did not consider it that important since the labs involved were only Hemoglobin A1C labs. The Medical Records LPN explained that it is important to ensure labs are completed timely and in accordance with the physician's orders because the results allow the provider to determine whether the resident's blood sugar is being regulated. She states that not completing the labs could cause all sorts of problems for the residents. In an interview with the DON on 8/5/26 at 3:37 PM, she acknowledged that the Hemoglobin A1C labs for Resident #43 were also not drawn as ordered and confirms that this resident's A1C was due in July as well. During an interview with the Administrator at 12:44 PM on 8/6/26, she explained that she expects her staff to ensure labs are completed as per the physician's orders, as this can help aid in the prevention of negative outcomes in the health of the residents. Resident #105 A record review of the "Admission Record" revealed the facility admitted Resident #105 on 4/7/26 with			F0684			

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F0684 SS = E	Continued from page 5 diagnoses including type 2 diabetes mellitus without complications and end stage renal disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/26 revealed a Brief Interview Mental Score (BIMS) of (12), indicating the resident is cognitively intact. A record review of the "Order Summary Report" revealed an order dated 4/8/26 for Hemoglobin A1C labs every three (3) months (January, April, July, October). Resident #43 A record review of the "Admission Record" revealed the facility admitted Resident #105 on 7/16/24 with diagnoses including type 2 diabetes mellitus without complications, and chronic kidney disease, stage (3). A record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/15/26 reveals a Brief Interview Mental Score (BIMS) of fifteen (15), indicating the resident is cognitively intact. A record review of the physician orders revealed Hemoglobin A1C labs every three (3) months (July, October, January, Apri).	F0684					
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F0880					

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F0880 SS = E	Continued from page 6 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880					

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F0880 SS = E	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to follow hand hygiene and infection prevention practices for two (2) of three (3) care observations. Resident #3 and #95. Findings include: Record review of the facility policy "Handwashing/ Hand Hygiene" with a revision date of 08/2015 revealed, "The facility considers hand hygiene the primary means to prevent the spread of infections... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors..." Resident #3 On 8/5/26 at 10:05 AM, Certified Nursing Assistant (CNA) #2 was observed providing urinary catheter care to Resident #3. CNA #2 gathered supplies, donned a gown, and entered the resident's room. CNA #2 filled a basin with warm water and applied gloves. While wearing the gloves, CNA #2 pulled back the resident's bed covers, adjusted the bed, and touched the privacy curtain before beginning catheter care. Resident #3 had feces in the brief. During care, CNA #2 removed her gloves and applied clean gloves on two occasions without performing hand hygiene. CNA #2 did not perform hand hygiene before beginning care, between glove changes, or after completing care. During an interview on 8/5/26 at 10:38 AM, CNA #2 confirmed she did not perform hand hygiene before, during, or after Resident #3's catheter care. CNA #2 stated she forgot. CNA #2 acknowledged that failing to perform hand hygiene while providing catheter care could cause the resident to develop an infection. A review of Resident #3's "Admission Record" revealed an admission date of 3/24/25 with diagnoses that included neuromuscular dysfunction of the bladder and urinary tract infection. A review of Resident #3's "Order Summary Report" revealed an order dated 7/17/26 for an 18 French, 30 cubic centimeter indwelling urinary catheter and catheter care with soap and warm water every shift. A review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of		F0880				

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F0880 SS = E	Continued from page 8 5/27/26, revealed the resident was severely cognitively impaired. Resident #95 On 8/5/26 at 8:00 AM, Licensed Practical Nurse (LPN) #2 was observed administering medication to Resident #95. LPN #2 gathered supplies and gloves, knocked on the resident's door, and entered the room. LPN #2 applied gloves and administered one drop of latanoprost ophthalmic solution into each of the resident's eyes. LPN #2 did not perform hand hygiene upon entering the room or before applying gloves and administering the medication. During an interview on 8/5/26 at 8:30 AM, LPN #2 acknowledged she made a mistake and failed to perform hand hygiene before administering Resident #95's ophthalmic medication. LPN #2 stated she usually performed hand hygiene before administering medication. LPN #2 acknowledged that failing to perform hand hygiene could cause the resident to develop an eye infection. A review of Resident #95's "Admission Record" revealed an admission date of 5/20/25 with a diagnosis that included unspecified glaucoma. A review of Resident #95's "Order Summary Report" revealed an order dated 3/16/26 for latanoprost ophthalmic solution 0.005 percent, one drop in each eye once daily for glaucoma. A review of Resident #95's MDS with an ARD of 5/1/26, revealed a Brief Interview for Mental Status score of 9, which indicated moderate cognitive impairment. During an interview on 8/6/26 at 12:58 PM, the Infection Preventionist stated LPN #2 should have performed hand hygiene upon entering the resident's room and before administering the ophthalmic medication and CNA #2 should have performed hand hygiene upon entering the resident's room and between glove changes. The Infection Preventionist stated the failure created cross-contamination and the possibility of spreading infection. She stated she expected staff to follow the facility's infection prevention policies and procedures. During an interview on 8/6/26 at 1:37 PM, the Director of Nursing (DON) stated CNA #2 should have performed hand hygiene before beginning care and each time she changed gloves, and she expected LPN #2 to perform hand hygiene upon	F0880					

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F0880 SS = E	Continued from page 9 entering the resident's room and before applying gloves and administering medications or treatments. The DON stated she expected staff to provide care according to facility procedures and their training.	F0880					
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility policy review, and record review, the facility failed to provide oral care in accordance with physician's orders for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL) care. Resident #52. Findings Include: Record review of the facility policy "Mouth Care" revised February 2018 revealed, " The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection..." Record review of the facility policy "Resident Rights" revised December 2016 revealed, "...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to... a dignified existence; b. be treated with...dignity..."On 8/3/26 at 2:30 PM, Resident #52 was observed with visibly unclean teeth. Dried secretions, dried skin, and a thick white film were observed on the resident's teeth. On 8/5/26 at 9:22 AM, Resident #52's mouth was again observed to be visibly unclean. The resident had unclean teeth, thick oral secretions, and visible plaque on the teeth During an interview on 8/5/26 at 9:45 AM, Licensed Practical Nurse (LPN) #3 stated she had applied lip balm to Resident #52's lips that morning. LPN #3 stated staff cleaned the resident's mouth daily but acknowledged the resident's mouth had appeared this way since admission. During an interview on 8/5/26 at 11:07 AM, Certified Nursing Assistant (CNA) #1 stated CNAs were responsible for cleaning Resident #52's mouth daily. CNA #1 stated she completed the resident's oral care at approximately 10:00 AM that morning. CNA #1 stated she was unsure whether the night-shift	F0677					

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F0677 SS = D	Continued from page 10 staff consistently provided oral care because she worked the 3:00 PM to 11:00 PM shift. During an interview on 8/5/26 at 12:50 PM, the Director of Nursing (DON) confirmed Resident #52's mouth appeared visibly unclear that morning. The DON stated the resident's mouth was chronically covered with plaque, although the amount varied and improved when staff cleaned the resident's mouth. The DON confirmed oral care was not documented as completed on 7/26/26, 8/2/26, and 8/4/26. The DON stated CNAs were responsible for providing oral care twice daily. The DON stated she did not know why staff failed to provide the care on the identified dates. The DON stated failing to provide oral care could result in plaque buildup, cavities, and an increased risk of infection. The DON stated she expected CNAs to provide oral care twice daily and licensed nurses to intervene when CNAs did not provide the required care. The DON also stated the facility sent Resident #52 to a dentist during September 2025, but the dentist did not evaluate the resident because of an insurance or payment dispute. A review of the "Oral Care Task Record" for Resident #52 revealed oral care was not completed on 7/26/26, 8/2/26, and 8/4/26. A review of resident # 52's "Admission Record" revealed she was admitted on 6/20/24 with diagnoses that included aphasia following cerebral infarction. A review of resident #52's "Order Summary Report" revealed an order for Enteral Feed Order every shift Nasal/Oral Care completed dated 6/27/26. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/26 revealed a Brief Interview of Mental Status (BIMS) score of three (3) indicating cognitive skills were severely impaired.		F0677				
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:		F0867				

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

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NAME OF PROVIDER OR SUPPLIER MCCOMB COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 415 MARION AVE , MCCOMB, Mississippi, 39648			
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F0867 SS = D	Continued from page 11. §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of	F0867					

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F0867 SS = D	Continued from page 12 its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F0867					

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F0867 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop, implement, and maintain effective corrective actions and monitoring for two (2) of (2) previously identified quality-of-care concerns reviewed, oral care and hand hygiene. The facility was cited for these practices during its September 2024 recertification survey, and the same deficient practices recurred during the August 2026 recertification survey. Findings include: A record review of the facility policy, " Quality Assurance and Performance Improvement (QAPI) Program, no date, reveals, "... Implementation: The QAPI Committee oversees the QAPI Plan, which details the program's structure and activities. the committee tracks performance, establishes goals, identifies deficiencies, analyzes causes, implement corrective actions, and monitor improvements..." A review of the recertification survey conducted in September 2024 revealed that the facility was cited under F677 for not providing adequate oral care and under F880 for failing to ensure proper hand hygiene before administering care to residents. Resident #18 and Resident #73. A review of the current recertification survey August 2026 revealed the facility was again cited under F677 for not providing adequate oral care and under F880 for failing to ensure proper hand hygiene before administering care to residents. Resident #3 and Resident #95. In an interview with the Administrator at 12:26 PM, on 8/6/26, she explained that it is a practice of the facility to monitor their Quality Assurance and Performance Improvement Program (QAPI) Plan, adding that continued monitoring is necessary as it helps identify care concerns to ensure there is no break in the quality-of-care residents receive. At 1:51 PM on 8/6/26, in an interview with the Director of Nursing (DON), she acknowledged that the facility was cited during the annual recertification in 2024 for not providing proper oral care and for not adhering to correct handwashing techniques prior to providing care. She explained that additional education is needed for Certified Nursing Assistants (CNAs) who provide Activities of Daily Living (ADL) that includes oral care, because inadequate oral hygiene can lead to cavities, pain, or infection. The			F0867			

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F0867 SS = D	Continued from page 14 DON further stated that the same level of attention is needed for handwashing practices, noting that CNAs require better monitoring and reinforcement of proper hand hygiene to prevent cross-contamination and reduce the risk of infection when providing care.			F0867			