

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER MANHATTAN COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4540 MANHATTAN RD , JACKSON, Mississippi, 39206			
(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 along with three (3) Complaint Investigations (CI MS #3159872, CI MS #3157993, and CI MS #3107443) at the facility from 8/17/26 to 8/20/26. CI MS #3159872 was investigated for quality of care/treatment. CI MS #3157993 was investigated for resident/patient/client rights, nursing services and CI MS #3107443 was investigated for quality of care/treatment, admission/transfer rights, nursing services, resident/patient/client rights. There were no citations related to the CIs. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F761, F809, F561, F677, F690 and F880. The facility held a license for 180 beds, with a census of 168.			F0000			
F0761 SS = E	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 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			F0761			

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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F0761 SS = E	Continued from page 1 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, interview, record review and facility policy review the facility failed to properly store medications, as evidenced by not removing expired insulin vials within the manufacturer's 28-day in-use period for two (2) of four (4) medication carts inspected. Findings Include: Record review of the facility's policy titled "Insulin Administration," dated 2001, revealed to provide guidelines for the safe administration of insulin to residents with diabetes. Check the expiration date, if drawing from an opened multi-dose vial. On 08/18/2026 at 2:55 PM, during an observation of medication cart #2 on the second-floor front hall with Licensed Practical Nurse (LPN) #4, one opened vial of Lantus insulin, 100 units per milliliter, was dated 07/19/2026. The vial had been open for 30 days and exceeded the 28-day in-use period. During an interview at that time, LPN #4 confirmed the vial should have been removed from the medication cart. LPN #4 stated insulin should be discarded after 28 days because administering insulin beyond the designated period could be dangerous to residents. LPN #4 also confirmed she had not checked the insulin stored on her medication cart that day. On 08/18/2026 3:10 PM, in an observation and interview cart check on the second-floor cart #1 with LPN #5 confirmed that two bottles of Lantus that were opened on 7/16/26, should have destroyed on 8/12/26. She also confirmed that Lispro opened on 7/16/26 should have been destroyed on 8/12/26 and one dated 7/18/26 should have been destroyed by 8/14/26. She stated she started to glance over the cart this AM but did not check the cart completely. She stated insulin should not be given after 28 days as it would not be effective after 28 days. On 08/19/2026 at 4:05 PM, during an interview, the Director of Nursing (DON) stated nurses were responsible for removing opened insulin from medication carts after 28 days. The DON stated nurses should inspect the medication cart for expired medications when assuming responsibility for the cart. The DON confirmed insulin kept beyond			F0761			

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F0761 SS = E	Continued from page 2 its designated in-use period might not effectively reduce elevated blood glucose levels.	F0761					
F0809 SS = E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to ensure residents received snacks at designated times and that diabetic residents received appropriate nighttime snacks as required for three (3) of (33) sampled residents. Resident #92, Resident #104, and Resident #141. Findings include: A record review of the facility, " Exhibit D Resident Bill of Rights" no date, reveals, " Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life..." The resident council meeting was convened on 8/17/26 at 2:00 PM with 11 residents present. Residents reported they were not aware snacks were available to them. They explained that a hydration cart occasionally came around with water and juice,	F0809					

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F0809 SS = E	Continued from page 3 but not consistently. They noted staff sometimes gave snacks to residents in the day room but did not bring snacks to residents' rooms or offer them in passing. Residents reported snacks were mainly provided during council meetings and activities. Resident #104 mentioned that, as a diabetic, receiving a snack at night would help because he is usually hungry after dinner. He added he did not know snacks were available, so he never asked staff. Resident #92 explained that residents receive only three meals a day, and snacks between meals would be beneficial because the time between meals can feel long. She added she saves her orange juice from breakfast to have something at night if her blood sugar drops, noting no one informed her snacks were available in the evenings. On 8/17/27 at 3:17 PM, Licensed Practical Nurse (LPN) #1 explained that Certified Nursing Assistants (CNAs) are usually responsible for going room to room and passing out snacks at 10 AM, 2 PM, and 6 PM. She noted the hydration cart had been sitting in its current location for at least an hour. On 8/17/26 at 3:27 PM, the State Agency (SA) observed a hydration cart on the second floor at the nurse's desk filled with snacks, but no staff were passing out the snacks. On 8/17/26 at 3:49 PM, the SA again observed the hydration cart across from the nurse's desk with no staff distributing snacks. On 8/17/26 at 4:01 PM, Resident #141, who is a diabetic, explained she cannot remember the last time staff gave her a snack or passed them out to residents. She noted she received a bag of chips today and believed it was because the SA was in the building. On 8/18/26 at 9:25 AM, Resident #104 reported he did not receive any snacks the night before on 8/17/26. On 8/19/26 at 9:04 AM, Resident #104 reported he did not receive a snack the night before on 8/18/26 and said he was very hungry. During a phone interview on 8/19/26 at 9:28 AM, CNA #1 (House Coordinator, day shift) explained that the dietary department provides snacks such as sandwiches, cakes, chips, and juice. She confirmed snacks are supposed to go out at 10 AM, 2 PM, and 6 PM. She indicated she assigns CNAs to pass out the cart, but sometimes CNAs cannot complete the task. She acknowledged that no communication			F0809			

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F0809 SS = E	Continued from page 4 system exists for other staff to take over if the assigned CNA does not pass out snacks. In a phone interview on 8/19/26 at 10:06 AM, CNA #2 (House Coordinator, evening shift) reported she does not assign a specific person to pass out snacks and believes it is a team effort. She explained she did not focus on ensuring snacks and sandwiches were distributed because she assumed someone else would handle it. She acknowledged she "dropped the ball" and added that no one informed her it was a specific responsibility. She noted it is important for all residents, especially diabetics, to receive snacks after dinner because their blood sugar could drop, and residents should not have to ask since dietary provides them. On 8/19/26 at 11:14 AM, Resident #141 reported she did not receive a snack or anything after dinner the previous night. On 8/20/26 at 11:57 AM, the Director of Nursing (DON) explained that the House Coordinator is responsible for assigning the task of passing out snacks. She reported that diabetic residents should receive a snack every night at 8 PM to prevent their blood sugar from dropping during the night. She added that staff are expected to go room to room with the cart and provide snacks to residents who are in their rooms. Resident #92 A record review of the "Admission Record" revealed the facility admitted Resident #92 on 8/22/23 with diagnoses that included Major Depressive Disorder Recurrent and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/26 reveals a Brief Interview for Mental Status (BIMS) score of (15) indicating Resident #92 is cognitively intact. Resident #104 A record review of the "Admission Record" revealed the facility admitted Resident #104 on 5/10/25 with diagnoses that included Type 2 Diabetes Mellitus with Chronic Kidney Disease. A record review of the MDS with an ARD of 7/29/26 revealed a BIMS score of (15) indicating Resident #104 is cognitively intact.			F0809			

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F0809 SS = E	Continued from page 5 Resident #141 A record review of the "Admission Record" revealed the facility admitted Resident #141 on 10/28/22 with diagnoses that included End Stage Renal Disease and Type 2 Diabetics Mellitus with Chronic Kidney Disease and Nutritional Deficiency. A record review of the MDS with an ARD of 6/17/26 revealed a BIMS score of (14) indicating the resident was cognitively intact.			F0809			
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and facility policy review the facility failed to honor the stated food preferences as evidenced by not serving residents with a variety of choices of fresh fruits, as evidenced by the facility continued to provide only			F0561			

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F0561 SS = D	Continued from page 6 bananas or no fresh fruit for three (3) of (33) sampled residents. Resident # 114, Resident #50 and Resident #166. This failure limited the residents' food choices and resulted in dissatisfaction with the meals provided. Findings included: A review of the facility policy titled "Resident Food Preferences," revised July 2017, revealed, "Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diets will be ordered only with the resident's or representative's consent...Policy Interpretation and Implementation...8. If the resident refuses or is unhappy with his or her diet, staff will create a care plan the resident is satisfied with..." Resident #114 During the Resident Council meeting on 8/17/26 at 2:30 PM, Resident #114 stated she had repeatedly requested more fresh fruit on her meal trays but received only bananas. She stated she preferred a variety of fresh fruits and vegetables. She reported that she ate the food provided because she felt she had no choice of healthier options. During an interview on 8/17/26 at 3:28 PM, the Dietary Manager acknowledged he was aware Resident #114 wanted more fresh fruit, specifically strawberries and grapes. He stated several residents had requested a greater variety of fresh fruit. He explained that he had to follow the facility's current ordering list and remain within the dietary budget. He acknowledged the facility should honor residents' food preferences. Record review of the "Admission Record" revealed the facility admitted Resident #114 on 3/5/21 with diagnoses that included Type 2 diabetes mellitus without complications. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/26 revealed Resident #114 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #50 During an interview on 8/20/26 at 12:04 PM, Resident #50 stated dietary staff periodically asked about his food preferences, but his meal trays did not reflect those preferences. He stated the facility did not provide the fruit he preferred. He reported	F0561					

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F0561 SS = D	Continued from page 7 that the facility previously served bananas, but the bananas were often overly ripe or rotten. He stated he had not received a banana or other fresh fruit in several months. Record review of the "Admission Record" revealed the facility admitted Resident #50 on 5/22/24 with diagnoses that included unspecified hyperlipidemia. Record review of the MDS with an ARD of 7/1/26 revealed Resident #50 had a BIMS score of 13, indicating the resident was cognitively intact. Resident #166 During an interview on 8/20/26 at 10:55 AM, Resident #166 stated she had been admitted a few weeks earlier and was already "burned out" on bananas. She stated bananas were the only fresh fruit she had received. She stated she would like other fresh fruit options, including strawberries or grapes. During an interview on 8/20/26 at 12:53 PM , the Administrator stated the Dietary Manager assessed residents' food preferences upon admission and quarterly. She stated the Dietary Manager could adjust the menu to meet residents' needs and preferences. She acknowledged residents had the right to choose the foods they received and that the facility should accommodate their needs and preferences. Record review of the "Admission Record" revealed the facility admitted Resident #166 on 8/11/26 with diagnoses that included unspecified hyperlipidemia and essential hypertension. Record review of the MDS with an ARD of 8/15/26 revealed Resident #166 had a BIMS score of 14, indicating the resident was cognitively intact.	F0561			
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, record review and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to a resident that	F0677			

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F0677 SS = D	Continued from page 8 was dependent for personal hygiene for one (1) of seven (7) care observations. Resident #119 Findings Include: Record review of the facility policy "Activities of Daily Living (ADLs), Supporting", with a revision date of 3/2018 revealed ,"Policy Statement: Residents will be provided with care, treatment and service as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral care..." On 08/17/2026 at 11:57 AM, Resident #119 is in bed watching TV. He has moderate facial hair. He stated he has not been shaved in the last 4 days. He states they shave him once a week. He stated he would like to be shaved every other day. He stated he does not like all hair on his face. On 08/18/2026 at 12:06 PM, an observation and interview revealed Resident #119 was in bed and watching tv. He remained unshaven. Resident #119 stated he likes to be clean shaved. On 08/19/2026 at 9:38 AM, during an observation and interview revealed Resident #119 was in bed watching tv with moderate facial hair. Certified Nursing Assistant (CNA) #3 was present in the room and was assigned to Resident #119 today. Resident #119 confirmed he wanted to be shaved. On 08/19/2026 09:42 AM, an interview with CNA #3 stated Resident #119 usually like a trim down. He stated he does not ask residents on bath days if he would like to be shaved. He stated he assumes that he would like a trim down. CNA#3 confirmed that Resident #119 wants to be clean shaved. He stated that a resident that prefers to be shaved, it could cause him not to feel good about himself when he is left unshaved. On 08/19/2026 2:36 PM, in an interview and observation with Resident #119 revealed he clean shaved and smiling. He verbalized he is pleased with getting shaved. On 08/19/26 at 3:59 PM, in an interview with the Director of Nursing (DON) stated Resident #119 has designated days for showering and shaving. She stated she expects CNA #3 to do ADL care in a timely manner which included shaving.	F0677					

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F0677 SS = D	Continued from page 9 On 08/20/2026 at 10:36 AM, during an interview, the Assistant Director of Nursing (ADON) stated she usually shaved Resident #119 and gave him a facial hair trim. She confirmed she had never asked Resident #119 whether he wanted a different type of shave and stated she should have asked him about his preference. Resident #119 Record review of Resident #119's Admission Record revealed the facility admitted the resident on 08/30/2022 with diagnoses that included restlessness and agitation and unspecified cataracts. Record review of Resident #119's Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. Section GG documented that Resident #119 was dependent on staff for personal hygiene.	F0677					
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F0690					

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F0690 SS = D	Continued from page 10 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to provide appropriate treatment and services during incontinent care, as evidenced by failure to fully clean the perineal area and only cleaning the buttocks area for one (1) of seven (7) care observations. Resident #12. Findings Include: Record review of the facility's "Perineal Care "with a revision date of 2/2018 revealed, "The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident skin condition... Steps in the procedure... For a female resident...9. c. Clean the perineal area using a fresh wipe for each downward cleaning motion from front to back Ensure the labia is open for through cleaning. d. Clean the buttocks perineum thoroughly, moving from inside outwards to the thighs...f. Remove gloves perform hand hygiene and replace them with clean set of gloves. Place a clean brief on the resident..." On 08/17/2026 at 3:15 PM, observed Resident #12 in bed watching tv. There was a foul smell of urine in the room. On 08/19/2026 at 9:09 AM, an observation of Resident #12 receiving peri care by Certified Nursing Assistant (CNA) #4 and assisted by CNA #5. CNA #4 did not perform hand hygiene upon entry. She applied clean gloves and removed the brief and turned resident on her left side. Resident #12 had feces in the brief and a protective dressing on the sacrum. CNA #4 wiped front to back and back to front several times. She stated that she will inform the nurse the dressing needs to be changed. After cleaning the buttocks, she placed a clean brief under the resident and turned her over and fastened the brief with dirty gloves on. On 08/19/2026 at 9:20 AM, an interview with CNA #5 confirmed that CNA #4 did not complete peri care. She stated CNA #4 wiped the buttocks front to back and back to front several times. She stated	F0690					

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F0690 SS = D	Continued from page 11 CNA #4 did not do peri care in the front. She stated the resident was placed at risk for infection. On 08/19/2026 at 9:25 AM, an interview with CNA #4 confirmed that she did not provide care in the vaginal area and wiped back to front and front to back. She stated Resident#12 could get an infection or urinary tract infection (UTI) when care is not done correctly. On 08/19/26 at 3:55 PM, in an interview the Director of Nursing (DON) stated that CNA #4 should have provided peri care by wiping front to back only. She stated peri care should have been done in the vaginal area as well. She stated not doing it completely can cause Resident #12 to get an infection or UTI. She stated she expects CNAs to use the clean technique and the inside out technique doing peri care. On 08/20/2026 10:09 AM in an interview with Licensed Practical Nurse (LPN) #3/Infection Preventionist (IP) stated CNA #4 should have started in the front. CNA#4 should wipe front to back and clean the vaginal area. She stated CNA #4 should not have touched clean brief and bed linens with dirty gloves on. She stated Resident #12 could get an infection from care she received. On 08/20/2026 at 10:26 AM, in an interview with the Assistant Director of Nursing (ADON) stated CNA #4 should have wiped from front to back. CNA #4 should have started care in the front. She stated CNA #4 exposed Resident #12 to UTI, and bacterial infection. She stated her expectations are for CNAs to care for residents as if they have their own family. She stated she expects staff to take pride in their work and treat residents with respect. Record review of Resident #12's "Admission Record" revealed an admission date of 7/18/25 with diagnoses that included Unspecified Dementia, unspecified severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. Record review of Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicates the resident had moderate cognitive impairment.	F0690					
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880					

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F0880 SS = D	Continued from page 12 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F0880					

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F0880 SS = D	Continued from page 13 the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to follow infection prevention guidelines for two (2) of seven (7) residents observed during medication administration and care observations. Resident #12 and Resident #138 Findings Include: Record review of the facility policy "Handwashing/Hand Hygiene" with a revision date of 8/2015 revealed, "Policy Statement: This facility considers hand hygiene the primary, means to prevent the spread of infections...7b. Before and after contact with residents...7h. Before moving from a contaminated body site to a clean body site during resident care...7m. After removing gloves..." Record review of the facility policy "Infection Prevention" revised April 2019 revealed, "Staff follows established facility infection control procedures (E.g. handwashing, antiseptic technique, gloves, isolation precautions, etc. for the administration of medications, as applicable. Resident #12 On 08/17/26 at 3:15 PM, Resident #12 was observed in bed watching television. A foul odor of urine was present in the resident's room. On 08/19/26 at 9:09 AM, an observation revealed			F0880			

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F0880 SS = D	Continued from page 14 Certified Nursing Assistant (CNA) #4, assisted by CNA #5, provided perineal care to Resident #12. CNA #4 did not perform hand hygiene upon entering the room. CNA #4 applied gloves, removed the resident's soiled brief, and turned the resident onto the left side. CNA #4 did not change gloves or perform hand hygiene during the care. CNA #4 touched the clean brief and bed linens with the same gloves used during the contaminated portion of the care. CNA #4 did not perform hand hygiene after completing the care. During an interview on 08/19/26 at 9:20 AM, CNA #5 confirmed CNA #4 did not perform hand hygiene throughout the perineal care. CNA #5 stated the failure placed Resident #12 at risk for infection. During an interview on 08/19/26 at 9:25 AM, CNA #4 confirmed she did not perform hand hygiene or change gloves during the care. CNA #4 stated Resident #12 could develop an infection or urinary tract infection when perineal care was not performed correctly. During an interview on 08/19/26 at 3:55 PM, the Director of Nursing (DON) stated CNA #4 should have performed hand hygiene upon entering the room, during care when her hands became contaminated, and upon leaving the room. The DON stated the failure to perform hand hygiene could cause Resident #12 to develop an infection or urinary tract infection. The DON stated she expected CNAs to use clean technique and an inside-out technique when providing perineal care. During an interview on 08/20/26 at 10:09 AM, Licensed Practical Nurse (LPN) #3, the facility's Infection Preventionist (IP), stated CNA #4 should have performed hand hygiene upon entering the room, during care, and after completing care. LPN #3 stated CNA #4 should have changed gloves and performed hand hygiene during the care and should not have touched the clean brief or bed linens with contaminated gloves. LPN #3 stated Resident #12 could develop an infection because of the care provided. During an interview on 08/20/26 at 10:26 AM, the Assistant Director of Nursing (ADON) stated CNA #4 should have performed hand hygiene upon entering the room, changed gloves and performed hand hygiene during the care, and performed hand hygiene after completing the care. The ADON stated CNA #4 exposed Resident #12 to the risk of a urinary tract infection or bacterial infection.			F0880			

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F0880 SS = D	Continued from page 15 Record review of Resident #12's "Admission Record" revealed an admission date of 07/18/25 with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. Record review of Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/19/26, revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Resident #138 On 08/19/26 at 8:59 AM, while preparing medications for Resident #138, LPN #2 used her bare, ungloved hand to remove an Acidophilus tablet. LPN #2 placed the tablet into a medication cup with the resident's other morning medications. LPN #2 then administered the medications to Resident #138, who ingested them. During an interview immediately following the observation, LPN #2 confirmed she touched the medication with her bare hand. LPN #2 stated nurses should avoid touching medications or anything a resident might ingest with their bare hands because pathogens could be transmitted to the resident. LPN #2 stated failure to follow medication administration and infection prevention practices could increase the resident's risk for infection. During an interview on 08/19/26 at 3:37 PM, LPN #3, the facility's IP, stated nurses should never touch medications with their bare hands. LPN #3 stated touching medications with bare hands could expose residents to pathogens, even if hand hygiene was performed before medication administration. LPN #3 stated she expected staff to follow the facility's infection prevention practices when caring for residents. During an interview on 08/19/26 at 3:58 PM, the DON stated nurses should avoid touching medications with their bare hands to prevent transmitting pathogens to residents. The DON stated she expected staff to follow infection prevention practices during medication administration. The DON stated failure to follow infection prevention practices increased residents' risk for infection. Record review of Resident #138's "Admission Record" revealed the facility admitted the resident on 11/1/24 with diagnoses that included hemiplegia and hemiparesis.	F0880					

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F0880 SS = D	Continued from page 16 Record review of Resident #138's "Order Summary" revealed an order for Acidophilus Probiotic Oral Tablet, Lactobacillus, one tablet by mouth once daily for irritable bowel syndrome, with a start date of 07/14/26. Record review of Resident #138's Medication Administration Record revealed Acidophilus was documented as administered at 9:00 AM on 08/19/26. Record review of Resident #138's MDS with an ARD of 07/3/26, revealed a BIMS score of 15, indicating the resident was cognitively intact.			F0880			