

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255308		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CTR INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE , WIGGINS, Mississippi, 39577			
(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 at the facility from 9/8/26 through 9/10/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F657, F658, F698, F699, F812, and F880. The facility had a census of 51 and was licensed for 59 beds			F0000			
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). (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)-			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 = D	Continued from page 1 (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 interviews, record review, and facility policy review, the facility failed to develop comprehensive person-centered care plans that addressed, identified and individualized care needs by failing to: 1) develop individualized interventions addressing orthostatic hypotension and episodes of decreased blood pressure associated with position changes; and 2) identify and develop individualized interventions addressing behavioral triggers for a resident diagnosed with Post-Traumatic Stress Disorder (PTSD) who exhibited aggressive behavioral symptoms, for two (2) of (15) residents reviewed for comprehensive care plans. Residents #6 and #8. Findings include: A review of the facility's policy titled "Comprehensive Care Plan," revised 05/01/2026, revealed "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet each resident's medical, nursing, mental, and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality..." Resident #8 A record review of Resident #8's "Care Plan Detail" revealed the resident had a diagnosis of Post-Traumatic Stress Disorder (PTSD) and exhibited aggressive behavioral symptoms; however, the care plan did not identify individualized PTSD-related			F0656			

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F0656 SS = D	Continued from page 2 behavioral triggers or interventions addressing identified triggers. A record review of Resident #8's "Admission Record" revealed the facility readmitted the resident on 08/24/2026 with diagnoses including Fracture of Unspecified Part of the Right Mandible, Subsequent Encounter for Fracture with Routine Healing. A record review of Resident #8's "Order Summary Report" revealed an active physician's order dated 08/28/2026 for Haloperidol 1 milligram (mg) by mouth in the evening related to schizophrenia, unspecified. A record review of Resident #8's Significant Change in Status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2026, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired. On 09/09/2026 at 9:59 AM, during an interview, the Director of Nursing (DON) stated he was unaware of Resident #8's specific behavioral triggers. The DON stated asking the resident to sit down could trigger a behavioral response; however, he further stated almost anything could trigger the resident's behaviors and staff did not know the resident's specific triggers. On 09/09/2026 at 10:20 AM, during an interview, Social Services Designee (SS #1) stated Resident #8 had been admitted to the facility on 07/29/2026 with a diagnosis of PTSD. SS #1 stated the facility had not completed an evaluation following admission to identify the resident's behavioral triggers. SS #1 further stated she observed Resident #8 responded more favorably to directives provided by female staff than directives provided by male staff. The State Agency (SA) asked whether the resident's more favorable response to female staff or other individualized behavioral approaches had been incorporated into the comprehensive care plan so staff on all shifts would be aware of effective approaches. SS #1 stated they had not. Resident #6 A record review of Resident #6's medical record revealed no individualized care plan focuses, goals, or interventions addressing the resident's orthostatic hypotension and episodes of decreased blood pressure associated with position changes from lying to sitting and sitting to standing, including during Activities of Daily Living (ADL) care.			F0656			

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F0656 SS = D	Continued from page 3 A record review of Resident #6's "Admission Record" revealed the facility admitted the resident on 07/31/2026 with diagnoses including Urinary Tract Infection, site not specified. A record review of Resident #6's "Progress Note," dated 07/31/2026, revealed Orthostatic Hypotension (decreased blood pressure). A record review of Resident #6's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2026, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was severely cognitively impaired. A record review of Resident #6's "Order Summary Report" revealed an active physician's order dated 8/3/26 for skilled physical therapy services five (5) times weekly for 15 weeks for gait and transfer training, bed mobility, bilateral lower-extremity and core strengthening, and safety and fall-prevention training. On 09/10/2026 at 9:58 AM, during an interview, the Rehabilitation Director stated Resident #6's therapy sessions had been shortened due to contact precautions and episodes of significant orthostatic hypotension during therapy. The Rehabilitation Director stated the resident's blood pressure decreased to approximately 70/40 millimeters of mercury (mmHg) when transitioning from a lying position to sitting and then standing, causing the resident's blood pressure to "bottom out." On 09/10/2026 at 1:48 PM, during a follow-up interview, the Rehabilitation Director stated staff should have been aware that Resident #6 experienced orthostatic hypotension because the resident frequently remained in a lying position. The Rehabilitation Director further stated nursing staff had reviewed the resident's blood pressure readings and determined the resident's blood pressure had been sporadically low on some days and higher on other days. On 09/10/2026 at 2:07 PM, during an interview and review of the comprehensive care plans for Residents #6 and #8, the Care Plan Coordinator stated Resident #8's PTSD-related triggers had not been identified, and the care plan did not contain individualized interventions addressing PTSD-related triggers. The Care Plan Coordinator further confirmed Resident #6's comprehensive care plan did not contain individualized interventions			F0656			

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F0656 SS = D	Continued from page 4 addressing orthostatic hypotension during Activities of Daily Living (ADL) care. The Care Plan Coordinator stated the purpose of the comprehensive care plan was to provide all disciplines with a tool to guide the provision of care according to each resident's individualized needs. The Care Plan Coordinator further stated care plans were updated quarterly and when changes in condition, physician orders, or behavioral symptoms occurred. On 09/10/2026 at 2:12 PM, during a follow-up interview, the Care Plan Coordinator stated Resident #6's comprehensive care plan did not address orthostatic hypotension when transitioning from lying to sitting or sitting to standing during ADL care. The Care Plan Coordinator stated information used to develop and update residents' care plans was obtained from the physician, nurse practitioner, therapy, activities, residents, and residents' families. The Care Plan Coordinator further confirmed Resident #6's episodes of decreased blood pressure had not been addressed in the comprehensive care plan despite all staff having access to the care plan. The Care Plan Coordinator stated care plans were reviewed and updated quarterly, annually, and when significant changes occurred, including medication changes, new physician orders, falls, declines in condition, or behavioral changes. On 09/10/2026 at 5:39 PM, during an interview, the DON stated his expectation was for all comprehensive care plans to be individualized and person-centered. The DON stated he planned to provide additional education to the newly assigned Care Plan Coordinator regarding the development of individualized, person-centered comprehensive care plans that addressed each resident's specific needs and interventions.	F0656					
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F0657					

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F0657 SS = D	Continued from page 5 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to revise a resident's comprehensive person-centered care plan following a fall resulting in a fracture of the proximal right femur by failing to develop additional or revised interventions addressing the resident's risk for falls and injury, for one (1) of (15) residents reviewed for comprehensive care plans. Resident #9. Findings Include: A record review of the facility's policy titled "Comprehensive Care Plan" revision date of 05/01/2026 revealed "...Policy Explanation and Compliance Guidelines...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6...Alternative interventions will be documented, as needed..." A record review of Resident #9's "Care Plan Report" revealed a focus addressing the resident's risk for falls and injury; however, the care plan did not contain additional or revised interventions following the resident's 06/01/2026 fall resulting in a fracture of the proximal right femur. A record review of Resident #9's "Admission Record" revealed the facility admitted the resident on 03/01/2022 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Subsequent Encounter for Closed Fracture with			F0657			

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F0657 SS = D	Continued from page 6 Routine Healing. A record review of Resident #9's "Comprehensive Minimum Data Set (MDS)" with Assessment Reference Date (ARD) of 06/11/2026 revealed the resident was severely impaired for Cognitive Skills for Daily Decision Making. A record review of Resident #9's "Incident Report," dated 06/01/2026, revealed the resident sustained a witnessed fall and was sent to the hospital for evaluation. A record review of Resident #9's staff written statement related to the fall, dated 06/01/2026, revealed the resident sustained a witnessed fall and was sent to the hospital. A record review of Resident #9's "Computed Tomography (CT) Scan," dated 06/01/2026, revealed a fracture of the proximal right femur. On 09/08/2026 at 12:31 PM, during an interview, Registered Nurse (RN) #1 stated Resident #9 sustained a witnessed fall and fractured the right hip. On 09/10/2026 at 3:44 PM, during an interview, Licensed Practical Nurse (LPN) #2, Care Plan Nurse, confirmed Resident #9's comprehensive care plan had not been updated following the fall resulting in the right hip fracture. LPN #2 stated she was aware of the resident's fall with injury and confirmed the care plan should have been updated. LPN #2 stated the purpose of updating the care plan was to implement interventions to prevent further falls. LPN #2 further stated she became the Care Plan Nurse after the fall in late June 2026. On 09/10/2026 at 3:49 PM, during an interview, the Director of Nursing (DON) confirmed Resident #9's comprehensive care plan should have been updated following the fall. The DON stated that at the time of the fall, the facility was undergoing a transition in care-plan responsibilities because he had been promoted and was training another nurse to assume his previous responsibilities. The DON stated the comprehensive care plan was used by all staff to guide the resident's care and acknowledged the care-plan update was missed during the transition.			F0657			
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans			F0658			

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F0658 SS = D	Continued from page 7 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to follow professional standards of practice by failing to obtain a physician's order for contact isolation and implement contact isolation for a resident with a left hip wound infection involving Methicillin-Resistant Staphylococcus aureus (MRSA) and Extended-Spectrum Beta-Lactamase (ESBL), for one (1) of two (2) residents reviewed for transmission-based precautions. Resident #30. Findings include: A record review of Resident #30's "Admission Record" revealed the facility admitted the resident on 09/01/2026 with diagnoses including Infection and Inflammatory Reaction Due to Internal Left Hip Prosthesis, Initial Encounter; MRSA Infection as the Cause of Diseases Classified Elsewhere; and ESBL Resistance. A record review of Resident #30's "Order Summary Report" revealed no physician's order for contact isolation. A record review of Resident #30's "Care Plan Detail" revealed an individualized care plan with focus concerns of "...The resident has MRSA-colonization: methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, infection and inflammatory due to internal left hip prosthesis, initial encounter..." and interventions including "...CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry..." On 09/08/2026 at 11:26 AM, during an observation of Resident #30, the State Agency (SA) observed signage on the resident's room door indicating "Contact Isolation." Two (2) containers with biohazard signage were observed inside the resident's room, and personal protective equipment (PPE) was available in containers in the hallway outside the resident's room. On 09/10/2026 at 11:10 AM, during an interview, a			F0658			

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F0658 SS = D	Continued from page 8 Certified Nurse Aide (CNA) stated Resident #30 had been on contact isolation since admission, with contact-isolation signage posted at the resident's door. The CNA stated contact isolation required staff to wear a gown and gloves when entering the resident's room and providing care. On 09/10/2026 at 11:50 AM, during an interview, Licensed Practical Nurse (LPN) #3 stated Resident #30 was admitted to the facility with a wound and a catheter and had been on contact isolation since admission related to MRSA and ESBL in the left hip wound. LPN #3 stated Personal Protective Equipment (PPE) was worn when entering the resident's room and when providing care. LPN #3 stated PPE was removed and discarded in the containers inside the resident's room before staff exited the room. On 09/10/2026 at 5:00 PM, during an interview and record review of Resident #30's "Order Summary Report," the Director of Nursing (DON) confirmed there was no physician's order for contact isolation. The DON stated Resident #30 remained on contact isolation related to the left hip wound infection and continued to receive intravenous antibiotics. The DON stated the Admission Nurse was responsible for entering admission orders; however, any nurse could have notified the physician or Advanced Registered Nurse Practitioner (ARNP) to obtain an order. The DON stated any nurse could have identified the missing order and confirmed staff were expected to obtain an order for contact isolation when an order was not present. On 09/10/2026 at 5:17 PM, during an interview, LPN #1 stated Resident #30 was admitted with a wound infection and required contact isolation due to the type of infection. After reviewing the "Order Summary Report," LPN #1 confirmed an order had not been obtained for contact isolation. On 09/10/2026 at 5:37 PM, during an interview, the Administrator stated he expected staff to follow professional standards of practice related to infection control and obtaining physician orders. The Administrator stated that if an order was required for contact isolation, he expected staff to follow professional standards of practice.			F0658			
F0698 SS = D	Dialysis CFR(s): 483.25(l) \$483.25(l) Dialysis. The facility must ensure that residents who require			F0698			

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F0698 SS = D	Continued from page 9 dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to maintain ongoing communication and collaboration with the dialysis facility regarding a resident's dialysis care and services when dialysis communication forms containing treatment-related information were not obtained following the resident's dialysis treatments for one (1) of (1) resident reviewed for dialysis services. Resident #64. Findings include: A record review of the facility's policy titled "Hemodialysis," revised 11/25/2025, revealed "...the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include...ongoing communication and collaboration with the dialysis facility regarding dialysis care and services..." A record review of Resident #64's "Admission Record" revealed the facility admitted the resident on 09/03/2026 with diagnoses including Hypertensive Chronic Kidney Disease with Stage five (5) Chronic Kidney Disease or End Stage Renal Disease. A record review of Resident #64's "Order Summary Report" revealed an active physician's order for dialysis at [proper name of dialysis facility] every Monday, Wednesday, and Friday at 2:00 PM. A record review of the facility's dialysis communication book revealed no dialysis communication forms for Resident #64 documenting communication between the facility and the dialysis facility regarding the resident's dialysis treatments. On 09/10/2026 at 2:41 PM, during an interview and a follow-up interview at 3:00 PM, the Director of Nursing (DON) stated Resident #64 received dialysis every Monday, Wednesday, and Friday and was transported to dialysis by the facility van. The DON stated Resident #64 had not returned from dialysis with the dialysis communication forms. The DON stated he spoke with the facility van driver, who confirmed the forms were not in the van. The DON stated the dialysis communication forms were			F0698			

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F0698 SS = D	Continued from page 10 expected to be returned to the facility because the forms contained the resident's vital signs and weights and communicated how the resident did during dialysis.	F0698					
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide trauma-informed care that accounted for a resident's experiences and individualized needs by failing to identify trauma-related triggers and individualized approaches to minimize triggers and the potential for re-traumatization for one (1) of (1) resident reviewed for trauma-informed care. Resident #8. Findings include: A record review of the facility's policy titled "Trauma Informed Policy," revised 08/06/2026, revealed "...It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, accounted for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization..." A record review of Resident #8's "Admission Record" revealed the facility readmitted the resident on 08/24/2026 with diagnoses including Fracture of Unspecified Part of the Right Mandible, Subsequent Encounter for Fracture with Routine Healing. A record review of Resident #8's Significant Change in Status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2026, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired.	F0699					

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F0699 SS = D	Continued from page 11 A record review of Resident #8's "Care Plan Report" revealed the resident had a diagnosis of Post-Traumatic Stress Disorder (PTSD). On 09/09/2026 at 9:59 AM, during an interview, the Director of Nursing (DON) stated he was unaware of Resident #8's specific behavioral triggers. The DON stated asking the resident to sit down could trigger a behavioral response; however, he stated almost anything could trigger the resident's behaviors and staff did not know the resident's specific triggers. On 09/09/2026 at 10:20 AM, during an interview, Social Services Designee (SS #1) stated Resident #8 had been admitted to the facility on 07/29/2026 with a diagnosis of PTSD. SS #1 stated the facility had not completed an evaluation following admission to identify the resident's behavioral triggers. SS #1 stated the resident exhibited behavioral symptoms after admission and was transferred to a behavioral hospital on 08/04/2026 for psychiatric evaluation and treatment and subsequently returned to the facility. SS #1 stated she observed that Resident #8 responded more favorably to directives provided by female staff than directives provided by male staff. The State Agency (SA) asked whether the resident's more favorable response to female staff or other individualized behavioral approaches had been incorporated into the comprehensive care plan so staff on all shifts would be aware of effective approaches. SS #1 stated they had not. On 09/09/2026 at 3:37 PM, during an interview, Resident #8's Resident Representative (RR), daughter, stated the resident's home had been burglarized in June 2026, and the resident had been severely beaten during the burglary. RR #1 stated Resident #8 was a veteran and had been diagnosed with PTSD before the burglary occurred. RR #1 further stated admitting staff were informed of the burglary and physical assault when the resident was admitted to the facility. On 09/09/2026 at 3:47 PM, the State Agency (SA) observed Resident #8 walking in the 100 Hall while staff attempted to redirect the resident to sit in his wheelchair near the nurses' station. Resident #8 yelled at visitors entering the facility, stating, "These random people are in my house," and "I don't know who these folks are in my house." A Certified Nursing Assistant (CNA) repeatedly attempted to redirect Resident #8; however, the resident continued to refuse to return to the wheelchair. On 09/09/2026 at 4:18 PM, during an interview, Certified Nursing Assistant (CNA #1), employed by			F0699			

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F0699 SS = D	Continued from page 12 the facility for approximately 1.5 years, stated Resident #8 had exhibited physically aggressive behaviors toward staff since admission. CNA #1 stated the resident had attempted to hit multiple CNAs during care and had attempted to fight staff. CNA #1 further stated that on the night of admission, Resident #8 attempted to urinate on staff and exhibited aggressive behaviors during the admission process. CNA #1 stated staff were unaware of the resident's behavioral triggers and had no knowledge of the resident's behavioral history prior to admission. On 09/10/2026 at 2:44 PM, during an interview, the Admission Coordinator stated a review of the resident's admission documentation showed Resident #8's daughter had informed the facility during the admission process of the resident's behaviors and diagnosis of dementia. On 09/10/2026 at 5:39 PM, during a follow-up interview with the DON, he stated his plan of action included working with Social Services to develop an evaluation or obtain a more detailed family history for residents admitted with PTSD to identify individualized behavioral triggers. The DON stated family members could provide information regarding residents' histories and behaviors during the admission process so triggers and individualized interventions could be identified earlier rather than after admission and after behavioral symptoms occurred. On 09/10/2026 at 5:46 PM, during an interview, the Administrator stated the facility was researching best practices for caring for residents diagnosed with PTSD and had obtained educational resources for residents with PTSD.	F0699			
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812			

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F0812 SS = D	Continued from page 13 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety by failing to label and date food brought into the facility for a resident and failing to discard milk that was past its expiration date during one (1) of two (2) kitchen observations. Findings include: A review of the facility's policy titled "Food Receiving and Storage" revised 07/2014 revealed, "...Policy Interpretation and Implementation...13...b. All foods belonging to residents must be labeled with the resident's name, the item, and the "use by" date..." On 09/08/2026 at 10:08 AM, during the initial kitchen tour, an observation of refrigerator #2 revealed one bowl of food brought into the facility by a resident's family that was not labeled or dated and (1) unopened gallon of milk with an expiration date of 09/01/2026. During an interview at that time, the Cook stated kitchen staff were responsible for labeling and dating food and maintaining the freshness of food stored in the kitchen and were expected to discard expired items. The Cook stated unlabeled, undated, or expired food could be consumed and could cause someone to become ill. The Cook further stated staff should do a better job of labeling food and knowing when to remove expired items from the food supply. On 09/09/2026 at 11:06 AM, during an interview, the Dietary Manager (DM) stated the cooks were responsible for checking food labeling and dating and discarding expired food. The DM stated unlabeled, undated, or expired food stored in the refrigerator could result in foodborne illness if consumed by a resident. The DM stated he expected			F0812			

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F0812 SS = D	Continued from page 14 kitchen staff to check food storage and discard expired items and properly label and date food. The DM further stated he planned to implement a flow chart to assist with maintaining food quality. On 09/10/2026 at 1:39 PM, during an interview, the Administrator stated he was aware of the unlabeled and undated food and expired milk identified in the kitchen. The Administrator stated the potential hazard of maintaining the food in the kitchen was that it could be provided to a resident. The Administrator stated he expected kitchen staff to routinely monitor food storage to maintain food freshness.	F0812			
F0880 SS = D	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 §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	F0880			

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F0880 SS = D	Continued from page 15 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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to perform hand hygiene prior to donning gloves during resident care to reduce the risk for transmission of infection for two (2) of eight (8) medication administration observations. Residents #4 and #14. Findings include: A record review of the facility's policy titled "Hand Hygiene," revised 09/01/2024, revealed "...all staff will perform proper hand hygiene procedures to	F0880					

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F0880 SS = D	Continued from page 16 prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility...The use of gloves does not replace hand hygiene. If your task requires gloves perform hand hygiene prior to donning gloves..." Resident #4 A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on 06/29/2026 with diagnoses including Other Acute Osteomyelitis, Right Femur. A record review of Resident #4's "Order Summary Report" revealed an active physician's order dated 9/9/26 for Vancomycin HCl Intravenous Solution 1500 milligrams (mg)/300 milliliters (mL), one (1) dose intravenously one time a day related to Other Acute Osteomyelitis, Right Femur, through 09/15/2026. On 09/09/2026 at 11:25 AM, during an observation, Registered Nurse (RN) #2 failed to perform hand hygiene prior to donning gloves before disconnecting Resident #4's intravenous (IV) line, cleaning the tubing connection, and flushing the IV with normal saline and heparin. On 09/09/2026 at 11:32 AM, during an interview, RN #2 confirmed she did not perform hand hygiene upon entering the resident's room and stated she should have performed hand hygiene prior to donning gloves. RN #2 stated she placed the resident at risk for infection. Resident #14 A record review of Resident #14's "Admission Record" revealed the facility admitted the resident on 12/13/2023 with diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy. A record review of Resident #14's "Order Summary Report" revealed an active physician's order dated 1/12/24 for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro), inject as per sliding scale. On 09/09/2026 at 11:05 AM, during a medication administration observation, RN #1 failed to perform hand hygiene prior to donning gloves before performing a blood glucose check for Resident #14 to determine whether sliding-scale insulin was required. On 09/09/2026 at 11:11 AM, during an interview, RN #1 confirmed she did not perform hand hygiene	F0880			

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F0880 SS = D	Continued from page 17 upon entering the resident's room or prior to performing the blood glucose check. RN #1 stated she placed the resident at risk for infection and the spread of bacteria. On 09/10/2026 at 3:53 PM, during an interview, the Director of Nursing (DON) stated staff should perform hand hygiene before providing resident care and were expected to follow facility policies and procedures. The DON stated failure to perform hand hygiene increased the risk for residents developing infections.			F0880			