STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255130	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tippah County Nursing Home	1005 City Avenue North Ripley, MS 38663

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on staff interviews, record review, and facility policy review, the facility failed to develop a care plan for hospice service for one (1) of 14 sampled residents' care plans reviewed. Resident #15 Findings include: Record review of the facility policy titled, MDS 3.0: Care Plans (Minimum Data Set) dated 6/23/16, revealed, The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 1. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being as required, 2. Any services that would otherwise be required. Record review of Resident # 15's physician's Order Details revealed an order dated 5/9/24 to Admit to (proper name of hospice company) hospice. Record review of the care plans for Resident #15 revealed there was no care plan for hospice care and services. During an interview on 11/6/24 at 11:45 AM, the Minimum Data Set (MDS) Coordinator revealed Resident #15 was receiving hospice services and was assessed for hospice on the MDS assessment, but a care plan was not developed. She acknowledged any resident receiving hospice services should have a care plan for that care, and she was uncertain why this one was not done. She stated the resident had been on and off of hospice and this care plan just slipped through the cracks and was not done. An interview with the Administrator on 11/6/24 at 11:55 AM, confirmed Resident #15 was receiving hospice services, therefore, a care plan for this was needed. She stated that she was uncertain why the care plan was not developed. She acknowledged the care plan provided the staff with a guide for the care of each resident and should include the plans/treatments/preferences for each resident and the facility failed to develop a hospice care plan for this resident. Record review of Resident #15's Transfer/Discharge Report revealed the facility admitted the resident to the facility on [DATE]. (continued on next page)

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's MDS Section O with Assessment Reference Date (ARD) of 8/12/24, revealed the resident was receiving hospice services. Section C revealed the Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely/never understood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure the proper storage of a nebulizer facial mask and tubing to prevent contamination and the possibility of infection for one (1) of fourteen sampled residents. Resident #21. Findings Include: Record review of the facility policy titled Oxygen/Nebulizer and Continuous Positive Airway Pressure (CPAP) Supplies with a revision date of 03/13/18 revealed .Place Oxygen/Nebulizer tubing/supplies and CPAP mask/supplies in plastic bag after each use An observation on 11/04/24 at 10:40 AM, revealed a nebulizer machine on the nightstand next to Resident #21's bed and the facial mask and tubing were not in a plastic protective covering. An interview with Licensed Practical Nurse (LPN) #1 on 11/05/24 at 11:40 AM, confirmed that Resident #21's nebulizer mask and tubing were placed on top of the nightstand and were not inside a plastic protective bag. She revealed that a respiratory mask left open to air was an infection control issue, the mask could become contaminated with different germs and could cause respiratory infections. LPN #1 confirmed that the nebulizer facial mask and tubing should be in a protective covering when not in use. An observation and interview with the Administrator (ADM) on 11/05/24 at 11:45 AM revealed that nebulizer facial masks and tubing should be in a protective bag when not in use to prevent infection. She confirmed that Resident #21's nebulizer mask and tubing were placed on top of the nightstand and were not in a protective plastic bag. She revealed that leaving the nebulizer facial mask and tubing out and open to air could cause the spread of germs and respiratory infection. Record review of Resident #21's Order Summary Report revealed an order with a start date of 07/01/24 for Albuterol Sulfate Solution Nebulizer 0.5% (5 milligrams per milliliter) 1 dose inhale orally via nebulizer every six hours as needed for coughing/wheezing. Record review of Resident #21's November Respiratory Record revealed that she received an albuterol breathing treatment by nebulizer on 11/04/24 at 8:23 AM and on 11/04/24 at 5:09 PM. Record review of Resident #21's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Shortness of Breath, Unspecified Dementia, and Chronic Obstructive Pulmonary Disease. Record review of Resident #21's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/05/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 06 which indicated that she had severe cognitive deficits.