

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

PRINTED: 02/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER J G ALEXANDER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25112 HIGHWAY 15 UNION, MS 39365		
(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	
E 000	Initial Comments	E 000			
	EMERGENCY PREPAREDNESS				
E 006	Survey conducted on 1/28/25 reveals the above facility must meets all applicable Federal, State and local emergency preparedness requirements. Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		2/22/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/17/2025

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.

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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed provide update the emergency preparedness (EP) plan per requirements of 42 CFR §483.73(a).	E 006	1) On 2/3/25, copies of after-action reports for community-based exercises for 2024 and 2025 were provided to the Physical Plant Manager from the Facility		

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E 006	Continued From page 2 Findings Include: On 1/28/25 at 9:45 AM, the facility failed to provide updated documentation of the emergency preparedness (EP) plan after action reports on all community-based exercises for the year 2024 and current year 2025. Documentation review revealed the facility provided a current EP plan dated for the year 2025. The findings were acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 1/28/25.	E 006	Business Office. (See Exhibit 006A) 2) All residents have potential to be affected by the same deficient practice. 3) On 2/3/25, Administrator-in-Training conducted in-service training to Physical Plant Manager and Maintenance Supervisor related-to location of emergency operation plan after-action reports. (See Exhibit 006B) 4) a. The Physical Plant Manager implemented quarterly EOP Record Review Audit on 2/3/2025 for three quarters to ensure proper storage and record-keeping of after-action reports for community-based exercises. (See Exhibit 006C) b. Beginning no later than 2/25/2025 QA will meet and receive the data related to all pertinent audit(s) and in-services on a quarterly basis for at least three quarters, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.		