STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO COMM LIVING CENTER	**1410 WEST QUITMAN STREET** **IUKA, MS 38852**

(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide smoke detection systems in spaces open to corridors as required by NFPA 101 section 19.3.6.1. The deficient practice affected one (1) of six (6) smoke compartments and 14 of 68 residents in facility on the day of survey. Findings Include: On 5/5/21 at 10:20 AM, observation revealed no hard-wired smoke detector protecting the Locker Room and Station 1 Dining Room of the facility. The Locker Room and Station 1 Dining Room were open to the main corridor and could not resist the passage of smoke throughout the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 5/5/21.	K 347	1. Maintenance Director requested quote on 05/06/2021 from fire protection companies Pye Barker and E-fire. Quotes received with E-Fire able to complete work on 05/25/21. E-Fire scheduled to complete installation of smoke detection systems in station 1 dining room and locker room on 05/25/2021. 2. An audit was preformed of facility by Maintenance Director on 05/06/2021 to ensure that no room open to corridors did not have a smoke detection system. The audit was negative for findings. 3. All staff were educated on emergency operations of fire and safety of residents, staff, and visitors by Assistant Director of Nurses on 05/07/2021 and completed on 05/10/2021.	5/25/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2021**

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K 347	Continued From page 1	K 347	4. Maintenance director will add new smoke detection system to monthly and quarterly checks upon installation. The checks will be conducted indefinitely, any findings will be brought to the Quality Assurance and Performance Committee for review, revision, and resolution.	