STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255312	A. BUILDING _____ B. WING _____	R 04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION CO HEALTH AND REHAB CENTER, INC	**1111 BRATTON ROAD NEW ALBANY, MS 38652**

(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
{F 000}	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 03/15/21 through 03/18/21, along with complaint investigations (CI), CI MS #17626, CI MS #17627, CI MS #17607, CI MS #17562, CI MS #17533, CI MS #17534, CI MS #17535, CI MS #17517, CI MS #17513, CI MS #17514, CI MS #17658, and CI MS #17661 all related to Quality of Care. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations of participation and substantiated CI MS #17513 at F609 related to failure to report an allegation of abuse and/or neglect. All other complaints were unsubstantiated. The SA also cited F623 related to failure to notify of a transfer and cited F880 related to infection control and failure of dietary staff to wear mask while in the kitchen. The census at time of the survey was 41 with a bed capacity of 60. Based on an acceptable PoC and desk review completed on April 13, 2021, the facility is in substantial compliance with the participation requirements of Medicare and Medicaid regulations effective April 5, 2021. Facility Point of Contact: Ray Jones, Administrator, rjones@unioncountyhr.com SA Point of Contact: Ruby L. Burns-Ward, 601-364-1119, ruby.burns-ward@msdh.ms.gov	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/28/2021

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.