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 _____	03/18/2021

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 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.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/5/21

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

Electronically Signed | 04/05/2021

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 _____	03/18/2021

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 623	Continued From page 1	F 623		

paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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 _____	03/18/2021

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 623	Continued From page 2	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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 _____	03/18/2021

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 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, interviews and facility policy review, the facility failed to notify the family in writing of a hospital transfer for one (1) of one (1) hospitalization investigated, Resident #41. Findings include: Review of the facility's "Transfer or Discharge, Emergency" policy, revised December 2016, revealed, to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures which includes, notify the representative (sponsor) or other family member in writing and verbally. On 03/15/21, at 02:43 PM, on initial tour an interview with Resident #41 revealed he did go to the hospital recently but cannot remember why. He thinks it was during the snow and ice storm. On 03/17/21, at 03:00 PM, an interview with the Administrator revealed the facility is not sending any written transfer notifications to the family of residents being transferred. The Administrator revealed he is aware of the regulation that requires a written notification, but the facility has not been mailing any notifications to the families. On 03/17/21, at 03:10 PM, an interview with the Director of Nursing (DON) and Social Services (SS) revealed they did not know that a written notice was supposed to be mailed to families when a resident is transferred to the hospital. They revealed they did not know of any staff currently mailing notification of transfers to families.	F 623	* On 03/18/2021 a written notification of a hospital transfer on 02/10/2021 of resident #41 was mailed to resident representative by Social Services Director. (attachment #5, F623) * All residents with a hospital transfer/discharge could be affected by this deficient practice. * Review of facility policies and procedure titled "Transfer, Discharge, Emergency" on 3/24/21 by facility Quality Assurance Committee with no recommended changes at this time. The Social Services Director or Administrative Assistant starting 04/04/21, will review each morning with the Quality Improvement Committee, the prior 24 hours, five times a week, for three months, hospital transfers or discharges, and mail written notification immediately to residents' representative. Weekend/holiday transfers and discharges will be mailed on the first business day following a weekend or holiday after the event. Social Services Director or Administrator will maintain a copy of the log and written mailed notices to present to the Quality Assurance Committee starting 04/04/21, each month. (attachment #6 F623) RN Supervisor or charge nurse will be responsible for maintaining transfer/discharge log at the nurses station and entering transfer/discharge data as events require beginning 04/04/21. RN Supervisor or charge nurse will be responsibile for	

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 _____	03/18/2021

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 623	Continued From page 4 On 03/17/21, at 03:23 PM, an interview with Registered Nurse #1, revealed she works in medical records and she has not and did not know if she was supposed to be sending notifications to families in writing when a resident is transferred to the hospital. Record review revealed Resident #41 was transferred to the hospital on 2/10/21. Resident #41 returned to facility on 2/16/21 to his existing room with diagnoses of Congestive Heart Failure exacerbation, Anxiety, and Diabetes Mellitus. The 5-day Minimum Data Set (MDS) dated 2/23/21 for Resident #41 documented a Brief Interview for Mental Status (BIMS) score of 15 which reveals no cognitive impairment.	F 623	bringing transfer/discharge log to morning Quality Improvement meeting (commonly known as "Stand-up) to be reviewed by Quality Improvement team, Social Services Director and or Administrator beginning 04/04/21. * The Social Services director or Administrative Assistant will maintain a log of all facility initiated transfers and representative notifications starting 4/5/21 (attachment #7, F623) and present to the Quality Assurance Committee at monthly Quality Assurance Committee meetings. Quality Assurance Committee will monitor facility initiated transfers/discharges monthly for three months starting on March 24 2021, and make recommendations if necessary to achieve and maintain compliance with written notification of transfer and discharge requirements for a period of four months beginning on March 24 2021.	
F 880 SS=E	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	F 880		4/5/21

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 _____	03/18/2021

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 880	Continued From page 5 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 §483.70(e) 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 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.	F 880		

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 _____	03/18/2021

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 880	Continued From page 6 §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 observation, interview and facility policy review, the facility failed to prevent the possible spread of infection by failure to wear a face mask covering by dietary employees in the dietary department for three (3) of three (3) observations. Findings include: Review of facility's "COVID-19, Prevention and Control Of" policy, dated September 2020, revealed, "this facility follows current guidelines and recommendations for the prevention and control of COVID-2019. This facility will follow the CDC (Centers for Disease Control and Prevention) recommendations to assist in prevention of respiratory germs into the facility in relation to COVID-19." This policy also revealed, "facemask will be worn, covering the nose and mouth by all staff and visitors while in the building, except when actively eating in designated areas while observing social distancing."	F 880	* On 03/18/2021 facility Administrator instructed dietary supervisor and dietary employees to don Personal Protective Equipment (face mask) immediately and to wear face mask upon entering the facility and at all times while in the facility. All dietary employees present, including dietary supervisor, complied with the command to put on and wear PPE immediately. Disciplinary Action was administered to Dietary Manager for failure to comply with or require those dietary employees under her supervision to wear masks (PPE) per infection control policy and procedure "COVID - 19 Prevention and Control" infection control protocols during Covid-19 Public Health Emergency per Administrator on 03/18/2021, at approximately 1300 hours. Dietary staff and supervisor received in-service on wearing PPE as required per infection control policy and procedure "COVID - 19 prevention and Control" on 3/24/21 (attachment #8)	

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 _____	03/18/2021

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 880	Continued From page 7 On 03/15/2021, at 10:30 AM , during the initial observation of the kitchen, two (2) dietary employees were in the kitchen area, the Dietary Manager, and another employee. Both employees were observed to not be wearing masks. During an interview on 03/15/2021, at 10:30 AM, the Dietary Manager (Dietary Staff #1) stated the facility is no longer in a COVID-19 outbreak, so the dietary employees are not wearing masks while in the kitchen. She stated they do wear masks when they leave the kitchen area. She stated most of the dietary staff have either had COVID-19 or have received the COVID-19 vaccinations. An observation on 3/16/2021, at 11:15 AM, revealed three (3) dietary employees in the kitchen area preparing food without wearing masks. An observation on 3/16/2021, at 2:30 PM, revealed the same three (3) dietary employees as observed earlier, in the kitchen area without wearing masks. An interview on 3/16/2021, at 2:35 PM, with the Dietary Manager (Dietary Staff #1), revealed the kitchen staff wore masks in the kitchen area when the facility was in a COVID-19 outbreak. She stated since they are not in an outbreak at this time, masks are not worn in the kitchen area. She stated they try to distance themselves in the kitchen. She stated they have been short staffed at times, so the three (3) of them "work long days together and are almost like family since they spend up to 13 hours a day together". She stated	F 880	* All staff and residents have the potential to be affected by this deficient practice. * On 3/24/2021 at 1030,the Quality Assurance Committee reviewed the policy titled "COVID-19, Prevention and Control of" with no recommendation for changes at this time. Dietary staff and facility staff was in-serviced (attachment #8) on "COVID-19, Prevention and Control" per Quality Assurance Nurse/Infection control preventionist on proper PPE and infection control compliance during Covid-19 PHE on 3/31/21, 4/1/21, 4/2/21. Quality Assurance/Infection Preventionist or staff development nurse will monitor dietary staff compliance of proper wearing of PPE (facial masks) twice daily, five times a week, starting 4/5/21. for three months and document findings on audit sheet. (attachment #9) Administrator will conduct random checks of dietary personnel once a day, starting 4/5/21, five days a week, for three months to ensure dietary personnel are wearing PPE (Face Masks)as required, results of random checks will be documented on audit sheet. (attachment #9) Dietary Manager will ensure acceptable face masks (PPE) are maintained, assessable and worn by dietary staff as required to meet requirements by CDC, Mississippi State Department of Health and Licensure, and facility policy during the Public Health Emergency. * Administrator will monitor results of audits and report the findings and actions	

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 _____	03/18/2021

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 880	Continued From page 8 since the governor of the state has decreased the mask mandate requirements, she thought it would be acceptable to not wear a mask in the kitchen area. She stated she has not had COVID-19 and has chosen not to take the vaccine at this point. She stated she has been in-serviced on Personal Protective Equipment (PPE) and mask use and knows the purpose is to decrease the transmission of diseases. An interview on 3/16/2021, at 2:38 PM, with Dietary Staff #2, revealed she tested positive for COVID-19 the week before Christmas. She stated she wore a mask at work when the facility was in a COVID-19 outbreak, but she has not worn a mask since facility is out of an outbreak. She stated most of the time, the employees are socially distanced while working so she thought it was fine to not wear a mask. She stated she had been in-serviced on PPE and mask use and knows the reason for wearing a mask is to decrease the spread of infections. An interview on 3/16/2021, at 2:40 PM, with Dietary Staff #3, revealed she tested positive for COVID-19 in March/April 2020. She stated she wore a mask while the facility was in an outbreak, but since the facility is not in an outbreak, she does not use one. She stated she is aware that masks decrease the spread of infection and stated she has been in-serviced on PPE and mask use. An interview on 3/18/2021, at 1:50 PM, with the Infection Control Nurse (ICN), revealed the facility employees have been in-serviced on PPE and mask use. The ICN stated all employees should be wearing a mask throughout the facility, including in the kitchen. The ICN stated none of	F 880	taken to the QA Committee monthly during the QA Committee meeting starting on March 24, 2021. Quality Assurance Committee will monitor beginning on March 24, 2021, the effectiveness of monitoring program and audits of PPE (face Masks) and make recommendations to achieve and maintain the required compliance with the dietary department wearing their PPE (Face Masks) in this facility starting on March 24, 2021, and continuing for a period of four months.	

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 _____	03/18/2021

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 880	Continued From page 9	F 880		

the facility employees, including the dietary employees, have been instructed of a change in mask use requirements and should still be following recommended guidelines. The ICN stated signs were posted to remind employees that even though the facility is not in an outbreak, masks are still required.

An interview on 3/18/2021, at 1:55 PM, with the Director of Nursing (DON), revealed the employees are required to be wearing masks while in the facility and have been in-serviced on PPE and mask use. The DON stated the state mask mandate changes made were not changed for health care facilities/long term care facilities and masks are still required in this facility. The DON confirmed the facility failed to follow infection control guidelines to decrease the likelihood of the spread of infection.

An interview on 3/18/2021, at 1:55 PM, with the Administrator (ADM), revealed the employees are required to be wearing masks while in the facility. The ADM stated the kitchen staff should be wearing masks while in the facility, both in the kitchen area and out of the kitchen area. The ADM stated the kitchen employees have not been informed that mask requirements have changed. The ADM confirmed the facility failed to follow infection control guidelines.

Record review of facility's in-service titled, "PPE/COVID-19 Education" dated 4/17/2020, revealed Dietary Staff #2's signature was on the in-service sign in sheet. Signatures of Dietary Staff #1 and Dietary Staff #3 were not on the in-service sign in sheet.