STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to ensure confidentiality and privacy of residents as evidenced by failure to pull privacy curtains and close doors prior to medication administration for three (3) of 14 medication pass observations.	F 164	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** For Unsampled Resident C, there was no identified adverse outcome from the alleged deficient practice of failing to pull the privacy curtain for medication administration. The resident's roommate is his spouse. For Unsampled Resident C, there was no identified adverse outcome from the alleged deficient practice of failing to close the door for medication administration. For Resident #2, there was no identified adverse outcome from the alleged deficient practice of failing to close the door for medication administration. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents had the potential to be affected by the alleged deficient practice of either failure to close the door or to pull the privacy curtain, if indicated, during medication administration. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Nursing Staff inserviced on 08.04.14 on Six Rights of Medication Administration and facility policy & procedure regarding medication administration. Inservices conducted by facility Nursing Director and Consulting Pharmacist. (Continued on Page 2 of 8.)	09.05.14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 09.01.2014

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
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 164	Continued From page 1 [Resident #2, Unsampled Resident C] Findings include: Review of the facility's policy entitled, "General Dose Preparation and Medication Administration", dated May, 2010 revealed the staff should observe each resident's privacy by pulling privacy curtains. Observation on 08/01/14 at 7:40 AM with Licensed Practical Nurse (LPN) #1 during medication administration for Unsampled Resident C revealed LPN #1 did not pull the privacy curtain between the occupied beds before administrating insulin. Observation on 08/01/14 at 9:40 AM with LPN #1 during medication administration for Unsampled Resident C revealed LPN #1 did not close the resident's door before giving medications. Interview on 08/01/14 at 9:40 AM with LPN #1 revealed, "I guess I should have pulled the curtain and closed the door but I was just so nervous. I forget." Observation on 08/01/14 at 9:55 AM with LPN #2 during medication administration for Resident #2 revealed LPN #2 did not close the resident's door before giving medications.	F 164	**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** The Nursing Director or Charge Nurse completes random medication administration observations monthly for three (3) months, to monitor compliance. Findings and corrective actions are reported monthly to the Administrator and to the Performance Improvement Committee for further review and recommendations, as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 164	Continued From page 2 Interview on 08/01/14 at 9:55 AM with LPN #2 revealed "I just forgot". Interview on 08/01/14 at 4:30 PM with the Director of Nursing (DON) concerning privacy during medication pass revealed no comment by the DON. The DON wrote on paper and shook head.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dignity of residents as evidenced by residents were served meals on disposable dishware during two (2) of three (3) meal observations. Findings include: Observation of Resident #3's dinner meal on 07/31/14 at 5:15 PM, revealed the Dietary Department served greens to the resident in a disposable bowl. The Dietary Department also served four (4) residents on A Hall vegetables in disposable bowls during the dinner meal observation on 07/31/14 at 5:00 PM.	F 241	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Upon notification to the Dietary Manager by Surveyor #1 on 08.01.14, 11:45 A.M., the Dietary Manager instructed the on-duty Dietary Staff to discontinue use of disposable containers for resident food service. Other Food Service employees received this instruction from the Dietary Manager on 08.02.14. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents were affected by the alleged deficient practice. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Food & Nutrition guideline #403 "Preparation, Display and Service of Food" was revised to include "...Food should not be served to residents or patients in disposable containers except during power outages or as directed by the Director, Food & Nutrition, or the Administrator...."	08.05.14

(Continued on Page 4 of 8.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 241	Continued From page 3 Observation of the Dietary Department on 08/01/14 at 11:15 AM, revealed dietary staff served coleslaw in disposable bowls. Observation, during same date and time, revealed clean empty bowls in clean dish area. Interview with Dietary Staff #1 on 08/01/14 at 11:15 AM, confirmed coleslaw was prepared and placed in individual disposable containers for services to residents. Interview with Dietary Manager (DM) on 08/01/14, at 11:45 AM, confirmed the facility had enough bowls and dishes to serve residents during mealtime, but dietary staff instead utilized disposable dishware. The DM confirmed standard dishes should have been utilized instead of disposable dishware. The facility admitted Resident #3 on 06/18/13. Resident #3's diagnoses included Rheumatoid Arthritis, Hypertrophy, Alzheimer's disease, and Atrial Fibrillation. Review of Resident #3's most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 06/03/14, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 03, indicating impaired cognition. The facility failed to provide a policy regarding dignity during mealtime.	F 241	**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Visible observation is conducted X2 at least three (3) days weekly by the Director, Food & Nutrition, and by the Nursing Director. Exceptions are addressed and reported to the LTC Performance Improvement Committee.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** For Unsampled Resident D and Unsampled Resident A, there was no identified adverse outcome from the alleged deficient practice of	08.22.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 323	Continued From page 4 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to properly secure medications during medication administration for one (1) of two (2) days of survey as evidenced by medication cart left unlocked with medications left unattended on top of the medication cart. Findings include: Review of the facility's policy entitled, "General Dose Preparation and Medication Administration", dated May, 2010, revealed facility staff should not leave medications unattended, and the facility should ensure medication carts are always locked when out of sight or unattended. Observation on 08/01/14 at 9:30 AM with Licensed Practical Nurse (LPN) #1 revealed LPN #1 failed to lock the medication cart ad left the cart unattended while giving medications to Unsampled Resident D. Interview on 08/01/14 at 9:30 AM with LPN #1 revealed the medication cart drawers open if the drawers not all lined up and the cart would not lock. LPN #1 stated she reported it to the Director	F 323	failure to lock the medication cart after obtaining medication for administration. For Unsampled Resident D, there was no identified adverse outcome from the alleged deficient practice of failure to lock the medication cart after obtaining medication for administration. A replacement medication cart was ordered on 08.01.14. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents had the potential to be affected by the alleged deficient practice. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Nursing Staff were inserviced on the Six Rights of Medication Administration and the Facility guideline regarding medication administration; inservices conducted by the Facility Nursing Director and the Consulting Pharmacist. A repair work order was filed, resulting in installation of a new lock on the (existing) medication cart. A replacement cart was received and placed in service, with removal of the deficient cart. (Continued on Page 6 of 8.)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 323	Continued From page 5 of Nursing but could not recall the date. Observation on 08/01/14 at 9:55 AM with LPN #2 during medication administration for Resident #2 revealed LPN #2 left a container of MVI with M (Multivitamin with Minerals) on top of medication cart while cart was unattended. An interview on 08/01/14 at 9:55 AM with LPN #2 confirmed medication was left on top of cart. Observation on 08/01/14 at 4:00 PM with LPN #1 during medication administration for Unsampled Resident A revealed LPN #1 left the medication cart unlocked and unattended while giving medication.	F 323	**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** **The Nursing Director or Charge Nurse is conducting a weekly random medication administration observation for three (3) months, with on-spot inservice when warranted. Compliance findings are reported to the LTC Performance Improvement Committee for review/recommendations.**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** For Unsampled Resident A and Unsampled Resident B, the attending physician and the Responsible Party of each were notified. Both residents were assessed by each shift for three (3) days for signs/symptoms of infection related to the alleged deficient practice of failing to properly clean the glucometer before or after a glucose finger-stick. No signs/symptoms were noted. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All Diabetes-diagnosed residents having finger-sticks had the potential to be affected. **[Continued on Page 7 of 8.]**	08.05.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 441	Continued From page 6 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs Isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by failure to clean and disinfect glucometers between residents for two (2) of four (4) blood glucose observations. [Unsampled Resident A and B] Findings include: Review of the facility's policy entitled, "General Dose Preparation and Medication Administration", revised 5/1/10, read to ,"Clean all reusable equipment or supplies".	F 441	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** DON and Consulting Pharmacist inserviced Rns and LPNs 08.04.14 on Facility policy related to proper cleaning/sanitizing of glucometers. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Nursing Director or Charge Nurse conduct a weekly medication administration observation, including glucose finger-sticks, for at least three (3) months to monitor compliance with appropriate technique. Findings are reinforced on the spot and reported to LTC Performance Improvement Committee for review and recommendations.	

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

PRINTED: 08/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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 441	Continued From page 7 Review of the facility's policy entitled, "Surface cleaning and disinfection with approved disinfectant towelette", dated January, 2008, revealed upon entering the room, the nurse should obtain a disinfectant wipe from dispenser, wipe equipment, and the equipment should remain wet for one (1) minute. After a procedure, the nurse should clean equipment for 1 minute. Observation on 07/31/14 at 3:35 PM with Licensed Practical Nurse (LPN) #1 revealed LPN #1 did not clean the glucometer before or after performing a glucose finger stick on Unsampled Resident A. Observation on 07/31/14 at 3:45 PM with LPN #1 revealed LPN #1 again did not clean the glucometer before or after a glucose finger stick on Unsampled Resident B. Interview on 07/31/14 at 3:45 PM with LPN #1 revealed, "I do all my patients and then go to the nurses station to clean it (glucometer). I don't have the cleaner on my cart because there's not enough room." Interview on 07/31/14 at 4:50 PM with Director of Nursing (DON) revealed the facility in-serviced LPN #1 on cleaning glucometers when she transferred to the nursing home. The DON stated LPN #1 told her she had "really messed up".	F 441		

2014 Survey: ederal COP Compliance

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

PRINTED: 08/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	**176 SOUTH MAIN STREET PONTOTOC, MS 38863**

(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 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide a complete manual fire alarm system as directed by NFPA 101 9.6, and NFPA 72 4-4.4.2.3. This deficiency one (1) of four (4) smoke compartments and 12 of the 43 of the residents in the facility at the time of survey. Findings include: On August 5, 2014 at 1:30 p.m., the maintenance person and surveyor found the signaling devices on the A Hall were not synchronized.	K 052	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Alarm System vendor reprogrammed the system so that all strobes flash in synchronization. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents had the potential to be affected by the same deficient practice. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Quarterly Fire Alarm Component Test Sheet was revised to include strobe synchronization check. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Strobe synchronization will be observed and logged during quarterly fire alarm component testing. Results are reported to the Safety & Emergency Preparedness Committee. Exceptions are addressed immediately.	08.28.14

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

Administrator 09/01/2014

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
	25A380	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	**176 SOUTH MAIN STREET** **PONTOTOC, MS 38863**

(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 052	Continued From page 1 4-4.4.2.3 In corridors where there are more than two visible notification appliances in any field of view, they shall be spaced a minimum of 55 ft (16.76 m) from each other or they shall flash in synchronization.	K 052		