STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 from 04/30/19 through 05/02/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F583, F623, F625, F656, F677, F732, and F812. The facility was licensed for 41 beds and had a census of 34, which included one (1) bed hold at the time of survey.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) 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. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		6/15/19

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

Electronically Signed | 06/11/2019

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
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to provide privacy during medication administration for one (1) of six (6) residents observed during medication administration, (Resident # 7). Findings include: A review of the facility's "Quality of Life - Dignity"policy, dated August 2009, revealed that the policy of the facility was that each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. The policy further included that the staff should promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. An observation, on 05/01/2019 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #3 administered oral medications and applied a lidocaine patch to each of Resident #7's bilateral below the knee amputations. When administering Resident #7's medications, LPN #3 failed to close the door to Resident #7's room	F 583	1) Licensed Practical Nurse #3 was in-serviced on June 6, 2019, on policies pertaining to providing privacy, quality of life/dignity, including residents rights by closing the door to residents room by the Administrator and the Director of Nursing. Resident #7 was assessed by the Director of Nursing for changes in behavior, and actions. The resident continues with his normal behavior and routine, with no evidence of physccocial harm observed on 5/2/19. 2) All residents have been identified as having potential to be affected by the same deficient practice. 3)All nursing staff will be in serviced on June 12, 2019 on policies pertaining to providing privacy, quality of life/dignity, including residents rights by closing the door to each resident's room by the Administrator and the Director of Nursing. In-service acknowledgement documentation will be obtained. Licensed Practical Nurse #3 will be observed weekly for four weeks during medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 583	Continued From page 2 which made the application of patches and medication administration visible to anyone passing in the hallway. During an interview, on 5/1/2019 at 9:29 AM, with Resident #7, he stated he wanted to have privacy when he received his medications, and wanted the door closed when the nurses put patches on his stumps. During an interview, on 5/1/2019 at 9:32 AM, with LPN #3, she stated she knew Resident #7 was adamant about his privacy. LPN #3 stated, "I didn't close the door, because I wasn't thinking about it." LPN #3 stated "I do know he likes his privacy."	F 583	administration to ensure resident's privacy is maintained, beginning June 6, 2019, and ending July 4, 2019, by the Administrator and or Director of Nursing. Random nurses will be observed monthly by the Quality Assurance Nurse and or Director of Nursing beginning on June 10, 2019. 4)A log with findings will be maintained. Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.	
F 623 SS=E	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 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 (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 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 (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). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the resident and/or the Resident Representative (RR)	F 623	1)The facility policy regarding notice of bed hold before/upon transfer was revised on June 10, 2019, by the Administrator to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 5 in writing of the resident's transfer to the hospital for two (2) of two (2) resident's reviewed for hospitalization, (Residents #29 and #35). Findings include: A review of the facility's "Transfer or Discharge Documentation" policy, with a revision date of December 2016, revealed when a resident was transferred or discharged from the facility, there would be documentation in the resident's medical record that an appropriate notice was provided to the resident and/or legal representative. The policy did not specify that notification to the resident and the resident's RR would be in writing. Resident #29 A review of Resident #29's Face Sheet revealed the resident was admitted by the facility on 3/27/19, and readmitted on 4/23/19. Review of Resident #29's Transfer and Referral Records revealed the resident was transferred to the hospital on 4/9/19 due to severe weakness, and on 4/14/19 due to irregular heart beat. There was no indication in the Resident #29's medical record the resident or the RR were notified in writing of the transfers. Resident #35 A review of Resident #35's Face Sheet revealed the resident was admitted by the facility on 01/17/19, and readmitted on 3/15/19, and discharged on 3/21/19. Review of Resident #35's Transfer and Referral Records, dated 3/20/19, revealed the resident was transferred to the	F 623	include written notification of bed hold before/upon transfer to the resident and or responsible party. Resident #29 did not return to the facility, but opted to discharge home from the hospital with hospice care. Written notice of transfer/discharge was given to the responsible party by the Administrator on 05/03/19. Resident #35 was transferred and admitted to the hospital on 03/21/19 and expired at on 04/03/19. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3)The nursing staff will be in serviced by the Director of Nursing, on the policy revision regarding written notice of bed hold policy before/upon transfer on June 12, 2019. In-service acknowledgement documentation will be obtained. The Nurse transferring the Resident will provide written notice of transfer to the Resident or Responsible Party and document that it was given in the nurses notes. Medicare nurses will perform random audits of documentation of written notice of bed hold notification before/upon transfer. These audits will be performed weekly beginning June 10, 2019, and ending July 5, 2019, then monthly, beginning July 8, 2019 and ending August 8, 2019, and quarterly thereafter. 4)Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 6 hospital, on 3/20/19. There Reason For Transfer was blank, but the Diagnosis was Acute Respiratory Distress. There was no indication in the resident's medical record the resident or the RR were notified in writing of the transfer. An interview, on 05/01/19 at 3:36 PM, with Registered Nurse (RN) #1, revealed the facility filled out a transfer form when residents were transferred to the hospital, and the form was sent with the resident to the hospital upon transfer. RN #1 stated the resident's representative (RR) was usually notified of the transfer verbally. RN #1 stated she was not aware of any written notice being given to the resident or the RP. An interview, on 05/01/19 at 4:21 PM, with the Administrator in Training (AIT), revealed the facility did not provide any written notice to the resident or the RR when residents were transferred to the hospital. An interview, on 05/02/19 at 8:03 AM, with the Director of Nursing (DON) and the AIT, confirmed the facility did not provide a written notice to residents or their RRs when residents were transfer to the hospital. The DON and AIT stated they had been unaware of the requirement of written notification of transfer, but had read the regulation yesterday and would be sending written notification in the future when residents were transferred.	F 623	further action is necessary to ensure compliance is achieved and sustained.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 625	Continued From page 7 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide the resident or Resident's Representative (RR) a notice of the bed hold policy upon transfer, for two of two 2 of 2) resident's reviewed for hospitalization. (Residents #29 and #35) Findings include: Review of the facility's policy titled, "Bed Holds	F 625	1)All nursing staff will be in serviced on providing written Notice of the Bed Hold Policy upon transfer by the Director of Nursing on 06/12/2019. In-service acknowledgement documentation will be obtained. Resident #29 was discharged to the hospital and opted to discharge home with hospice care. Written notice of bed hold policy was provided to the Responsible Party, by the Administrator on 05/3/19. Resident #35 was transferred	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 625	Continued From page 8 and Returns", with a revision date of March 2017, revealed prior to transfers and therapeutic leaves, the resident or resident representative would be informed in writing of the bed-hold and return policy. The policy further stated that prior to transfer, written information would be given to the residents and the resident representatives that explained in detail rights and limitations of bed holds, reserve bed payment policy as indicated by the state plan, per diem rates required to hold a bed beyond the state bed hold period, and details of the transfer. Resident #29 A review of Resident #29's Face Sheet revealed the resident was admitted by the facility on 3/27/19, and had two transfer records indicating the resident transferred to the hospital on 4/9/19 and 4/14/19. There was a document titled "Notice of Hospital Transfer/Therapeutic Leave which was signed by the Resident's Representative (RR) and dated 03/27/19, the date the resident was admitted to the facility. The form included a Bed Reservation Agreement, and stated if a hospital transfer or therapeutic leave became necessary, the facility would notify the resident and/or resident's Representative of the bed hold option. There were no forms signed and dated indicating the resident or Resident's Representative were informed of the bed hold policy upon transfer for the two transfer dates the resident was transferred to the hospital. Resident #35 A review of Resident #35's Face Sheet revealed the resident was admitted by the facility on 1/17/19, and had one transfer record indicating	F 625	and admitted to the hospital on 03/21/19 and expired on 04/03/19. 2)All residents have been identified as having the potential to be affected by the same deficient practice. 3)The Medical Records Clerk and/or the Director of Nursing will audit all transfer orders to ensure written notice of the Bed Hold Policy was provided to the Resident and/or the Resident Representative weekly for four weeks beginning on June 10, 2019 and ending on July 5, 2019, and monthly thereafter. Any problems identified will be documented on a Deficiency Form for corrections and/or counseling with staff if necessary. 4)Deficiency Forms will be reviewed weekly by the Administrator and Director of Nursing, then monthly by the Quality Assurance Committee then quarterly with the Medical Director to ensure compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 625	Continued From page 9 the resident was transferred to the hospital on 3/20/19. There was no indication in the resident's medical record the resident or the Resident's Representative were notified in writing of the transfer. There was a document titled "Notice of Hospital Transfer/Therapeutic Leave, which was signed by the Resident's Representative (RR) and dated 1/17/19, the date Resident #35 was admitted to the facility. The form included a Bed Reservation Agreement that stated if a hospital transfer or therapeutic leave became necessary, the facility would notify the resident and/or the Resident's Representative of the bed hold option. There was no form signed and dated indicating the resident or the Resident's Representative were informed of the bed hold policy upon transfer for the date Resident #35 was transferred to the hospital. An interview, on 05/01/19 at 3:36 PM, with Registered Nurse (RN) #1, revealed the resident or Resident Representative signs a bed hold policy when they are admitted to the facility. RN #1 was unaware if the bed hold policy was reviewed with the resident or the resident representative when residents were transferred to the hospital. An interview on, 5/02/19 at 8:03 AM, with the Administrator in training (AIT) and the Director of Nursing (DON), revealed the facility was having the resident or the Resident Representative sign a bed hold policy on admission and had not reviewed the bed hold policy, or provide it to the resident or the Resident's Representative when residents were transferred to the hospital.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 656	Continued From page 10 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 656	Continued From page 11 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, family interview and facility policy review, the facility failed to implement the Care Plan for nail care for Resident #15, for one (1) of 15 care plans reviewed. Findings include: A review of facility's "Comprehensive Assessments and the Care Delivery Process" policy, dated December 2016, revealed: "Comprehensive assessments will be conducted to assist in developing person centered care plans. Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions". A review of Resident #15's comprehensive care plan revealed a problem area of "impaired tissue integrity", with a problem onset date of 1/21/15. The goal was "resident will maintain current skin integrity" with a goal date of 6/08/19. The plan included to complete a weekly fingernail audit and indicate if the nails needed to be trimmed. There was a undated hand written intervention of family request- only mother to trim resident's nails. An observation, on 4/30/19 at 10:24 AM, with Certified Nurse Assistant (CNA) #1, revealed Resident #15 was lying in bed with obvious contractures of both hands. There was a hand	F 656	1)The Minimum Data Set Nurse revised the person specific care plan for Resident #15 on May 1, 2019 to include an appropriate goal for problem addressed in the care plan. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3) Random care plans will audited by the Medical Record's Clerk or the Quality Assurance Nurse to ensure care plans are person centered to include measurable goal. These audits will begin weekly on June 10, 2019, and ending July 5, 2019, then monthly thereafter. A log of findings will be maintained. 4)Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 656	Continued From page 12	F 656		

roll in his right hand, but none in his left hand. Resident #15 had long, jagged, nails and the left hand fingers were contracted with his nails pushing into his left palm. After observing the fingers pushing down into the palm of the left hand, CNA #1 opened the left hand to view the fingers and palm of the hand. Resident #15's ring finger left an approximately .5 inch indented area in the hand with a purple hue. Resident #15's right hand had a wash cloth (hand roll) in it, and although the nails were uneven and long there was no discoloration or indentions.

An interview, on 4/30/19 at 10:56 AM, with CNA #1 regarding Resident #15 nails, revealed she thought the resident's mother cut his nails.

An interview, on 4/30/19 at 2:20 PM, with the Director of Nursing (DON) revealed the resident's mother usually cut his nails, and the resident didn't want anyone to do it but her. The DON stated they were long and jagged. The DON stated the facility called the resident's mother today, and his mother said she would cut them on her next visit. The DON stated the mother visited 2-3 times per week depending on the weather.

An interview, on 4/30/19 at 2:38 PM, with Licensed Practical Nurse (LPN) #1/MDS (Minimum Data Set) Nurse, who revised care plans, revealed she added the intervention on this date to the care plan for only the mother to trim the resident's nails after the Social Worker spoke to the resident's mom regarding the resident's nails. LPN #1 stated, "We usually date the interventions as we put them on the care plan, but I didn't date the intervention today". LPN #1 then dated the intervention 04/30/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 656	Continued From page 13 An interview, on 5/01/19 at 10:20 AM, with Resident #15's mother, revealed, "I didn't tell them not to cut his nails. His daddy used to cut them, but now I try to do it because he can get combative and I'm afraid he'll hit somebody. But no, I did not tell them not to cut his nails". An interview, on /02/19 at 7:50 AM, with the DON and Administrator in Training (AIT), revealed Resident #15's mother visited often and the resident reacted to her better, and she was able to calm the resident so staff had gotten used to her cutting the resident's nails. The AIT stated it was not the parent's responsibility to cut the resident's nails, and it was the facility's responsibility. The DON stated she thought there was a communication error, and maybe it was just assumed the resident's mother wanted to do it because he did react to her better. An interview, on 5/02/19 at 10:53 AM, with LPN #2/Care Plan Nurse revealed, "I expect staff to follow a Care Plan if one is created for a resident. We make a ADL(Activities of Daily Living) sheet from the Care Plan for the CNAs to make is easier for them to understand the care Plan. All care Plans should be specific to the resident". An interview, on 5/02/19 at 11:00 AM, with LPN #1/Care plan/MDS Nurse, revealed the Care Plan is resident specific. It is the intent of the Care Plan if for the staff to follow that care plan to take care of the residents.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 677	Continued From page 14 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, record review, and facility policy review the facility failed to provide nail care to prevent the potential for skin breakdown and/or infection for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL) care (Resident #15). Findings include: A review of facility's policy titled, "Fingernails/Toenails, Care of", with a revision date of February 2018, revealed: "the purposes of this procedure are to clean the nail bed, to keep nails trimmed and to prevent infections." The procedure included, "Review the residents care plan to assess for any special needs of the resident". "Nail care includes daily cleaning and regular trimming", and "trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The procedure included that staff were to notify the supervisor if the resident refused the care. An observation, on 4/30/19 at 10:24 AM, with Certified Nursing Assistant (CNA) #1, revealed Resident #15 lying in bed with obvious contractures of both hands. There was a hand roll in his right hand, but none in his left hand. Resident #15 had long, jagged, nails and the left hand fingers were contracted with his nails pushing into his left palm. After observing the fingers pushing down into the palm of the left hand, CNA #1 opened the left hand to view the fingers and palm of the hand. Resident #15's	F 677	1)The fingernails of Resident #15 were trimmed and nail care was provided by the assigned Certified Nursing Assistant. Registered Nurse #2 was counseled on providing proper documentation of nail care by the Director of Nursing on 06/04/19. The care plans for Resident #15 were updated to reflect the preference of the Responsible Party for Resident #15 on 6/4/2019. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3)Registered Nurse Number #2, the facility nursing staff and the Certified Nursing Assistant will be re-educated on the importance of providing routine and as needed nail care to residents on 6/12/2019. Certified Nurse Assistant #1 and the Facility Certified Nursing Staff will be re-educated, by the Director of Nursing and/or Quality Assurance Nurse, on the importance of providing nail care on 6/12/2019. Nails will be monitored on random Residents weekly for 4 weeks beginning 6/13/2019 and ending 7/11/2019 and then monthly thereafter by the Charge Nurse, Director of Nursing, or Quality Assurance nurse to ensure proper nail care is provided. A log of findings will be maintained. Any problems identified will be reported promptly to the Administrator and or Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 677	Continued From page 15 ring finger left an approximately .5 inch indented area in the hand with a purple hue. Resident #15's right hand had a wash cloth (hand roll) in it, and although the nails were uneven and long, there was no discoloration or indentions. An interview, on 4/30/19 at 10:56 AM, with CNA #1, regarding Resident #15's nails revealed she thought the resident's mother cut his nails. A review or Resident #15's Treatment Record, for April 2019. revealed there was a treatment listed for weekly fingernail audit on body audit day. Staff filled in N for No and Y for Yes. The most recent Treatment Record entry, was dated 4/22/19, performed by Registered Nurse (RN) #2 with N being checked as nails not needing to be trimmed. A review of Resident #15's Minimal Data Set (MDS), with an Assessment Reference Date of 2/28/19, revealed Resident #15 required total assistance from staff for personal hygiene needs. An observation and interview, with the Director of Nursing (DON), on 4/30/19 at 2:10 PM, confirmed the resident had long nails with jagged edges on both hands, and a deep indention in the palm of his left hand that was purple in color with no broken skin. An interview, on 4/30/19 2:20 PM, with the DON revealed the resident's mother usually cut his nails, and the resident didn't want anyone to do it but her. The DON stated Resident #15's finger nails were long and jagged. The DON stated the facility called the resident's mother today, and his mother said she would cut them on her next visit. The DON stated the mother visited 2-3 times per	F 677	for corrective action. 4)Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 677	Continued From page 16 week depending on the weather. A review of Resident #15's Comprehensive Care Plan regarding skin integrity revealed an intervention written in with no date of "Family request- only mother to trim resident's nails". An interview, on 4/30/19 at 2:38 PM, with Licensed Practical Nurse (LPN) #1/MDS and Care Plan Nurse, revealed she added the intervention on this date to the care Plan for only the mother to trim the resident's nails after the Social Worker spoke to the resident's mom regarding the resident's nails. LPN #1 stated "We usually date the interventions as we put them on the Care Plan, but I didn't date the intervention today". LPN #1 then dated the intervention 4/30/19. An observation, on 5/01/19 at 9:18 AM, revealed Resident #15 lying in bed with hand rolls in both hands, nails long and jagged. An interview, on 5/01/19 at 10:20 AM, with Resident #15's mother, revealed, "I didn't tell them not to cut his nails. His daddy used to cut them but now I try to do it because he can get combative and I'm afraid he'll hit somebody. But no I did not tell them not to cut his nails". An interview, on 5/02/19 at 7:50 AM, with the DON and Administrator in Training (AIT) revealed the AIT stated it was not the parent's responsibility to cut the resident's nails, and it was the facility's responsibility. The DON stated she thought there was a communication error, and maybe we just assumed she wanted to do it because he does react to her better. Resident #15's mother visited often and the resident	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 677	Continued From page 17 reacted to her better, and she was able to calm the resident, so staff had gotten used to her cutting the resident's nails. An interview, on 5/02/19 at 11:03 AM, with the Social Service Director revealed, "I spoke to Resident #15's mother about the nails. She said she was coming to the facility the next day and she would cut them. She did not demand us not to cut the nails, she just stated she was coming to visit and she would do it. She would never command us not to do something, but she just likes to care for him as much as possible. That's just the type of person she is. But it is the facilities responsibility to make sure his nails were trimmed. We get used to family members doing things for their loved ones that we just forget it is our responsibility to check and make sure things are done."	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 732	Continued From page 18 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to post the required staffing information for three (3) of three (3) days of survey. Findings include: A review of the facility's policy titled, "Posting Direct Care Daily Staffing Numbers," dated July 2016, revealed the policy included staffing would be posted on a daily basis for each shift with the number of nursing personnel responsible for providing direct care to residents. Staffing information was to be recorded on the "Nurse Staff Directly Responsible for Resident Care" form for each shift to include: the name of the facility, the date for which the information was	F 732	1)The nurse staffing qualifications posting information was corrected to include the facility name, census, actual hours worked by the individual staff types and categories of licensed and non-licensed staff per shift, and the date. These corrections were made by, the Director of Nursing, and posted on 05/7/19. The Director of Nursing was in serviced on the facility policy for Posting Direct Care Daily Staffing Numbers, by the Administrator. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3)The Administrator will perform weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 732	Continued From page 19 posted, the resident census at the beginning of the shift for which the information was posted, a 24 hour shift schedule, the shift for which the information was posted including type of staff (RN/Registered Nurse, LPN/Licensed Practical Nurse, LVN/Licensed Vocational Nurse, or CNA/Certified Nursing Assistant) and category (licensed or non-licensed) of nursing staff working during the shift, the actual time worked during that shift for each category and type of nursing staff, and the total number of licensed and non-licensed nursing staff working for the posted shift. An observation during the initial tour of the facility, on 4/30/2019 at 9:10 AM, revealed it was observed that an untitled facility form, which indicated the facility's nurse staffing hours, was posted on a bulletin board on the 300 Hall. The facility form was observed to be incomplete. A review of the facility form, which was untitled, revealed it was dated 4/30/2019, and the staffing information was incomplete. The facility form did not indicate the census of the facility, the correct information in regards to the "Actual Hours" worked by the individual staff types and categories, or the correct information in regard to the total number of licensed and non-licensed nursing staff working with residents per shift. During an interview, on 4/30/2019 at 10:15 AM, with the Director of Nursing (DON), it was revealed that the staffing hours are posted daily. The DON stated that the information on the existing form, was the only information that she was taught to put on the form. An observation with review of an undated facility	F 732	audits of the posted nurse staffing qualifications to ensure compliance is maintained. Weekly inspections will be conducted beginning on June 10, 2019, and ending on July 5, 2019, then monthly thereafter by the Administrator. A log of findings will be maintained. Any problems identified will be corrected including corrective action if needed. 4)A log of Findings will be reviewed and maintained by the Quality Assurance Committee and the Medical Director quarterly to ensure compliance is achieved and sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 732	Continued From page 20 form documenting revealed the nurse staffing hours was not complete on 5/1/19 at 9:03 AM. The form was dated 5/1/19, but did not indicate the census of the facility, the correct information in regards to the "Actual Hours" worked by the individual staff types and categories, or the correct information in regard to the total number of licensed and non-licensed nursing staff working with residents per shift. An observation with review of an untitled facility form revealed the nurse staffing hours was not complete on 5/2/19 at 8:31 AM. The form was dated 5/2/19, but did not indicate the census of the facility, the correct information in regards to the "Actual Hours" worked by the individual staff types and categories, or the correct information in regard to the total number of licensed and non-licensed nursing staff working with residents per shift. During a follow-up interview, on 5/2/2019 at 12:46 PM, with the DON, it was confirmed that the posting of the nurse staffing information was not correct. The DON stated that she had only followed how the last person responsible for filling out the form had been doing it. The DON stated, "I just read the policy on how it was supposed to be completed."	F 732		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		6/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 812	Continued From page 21 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the kitchen equipment used to prepare meals was cleaned to prevent the for food borne illness for all residents served meals from the kitchen, for one (1) of three (3) days of survey. Findings include: A review of the facility's policy titled, Area and Equipment Cleaning Frequency/Schedules", with an effective day 3/1/2018, revealed, "A cleaning frequency is determined for all areas and equipment in the Food and Nutrition Services Department. An area and frequency cleaning listing serves as a basis for assignment of cleaning duties to staff and sanitation inspections. All staff is trained and assigned areas and equipment cleaning tasks pertinent to their area." An initial observation of the facility's kitchen area, on 4/30/19 at 9:20 AM, with Dietary Staff #1 revealed the following concerns:	F 812	1)The mixer, toaster, oven, hood filters and food warmer were thoroughly cleaned on 04/30/19 by the Dietary staff. The Administrator and the Dietary Manager conducted a thorough inspection of the dietary department on 05/09/19 and found the dietary department to be clean. The cleaning schedule was revised by the Dietary Manager on 05/03/19 to include the cleaning of the mixer, toaster, oven, hood filters, and food warmer as well as the specific person/position responsible for cleaning. The stove hood was cleaned by a local steam cleaning company, on 05/06/19. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3)The Quality Assurance nurse and or Dietary Manager will inspect the cleanliness of Dietary Department, including the mixer, toaster, oven hood	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 812	Continued From page 22 -The Mixer had dried food on the shaft of the mixer and underneath the mixer where the beaters were attached. Dietary Staff #1 stated she did not think the mixer had been used since the previous day. - The toaster had a build up of what appeared to be burnt bread crumbs on the floor of the toaster. Dietary Staff #1 agreed there were more than a day's worth of crumbs on the floor of the toaster. - The food warmer cart had dried food spilled inside the warmer and on the outside bottom the lip of the warmer. Dietary Staff #1 confirmed the observation. - The vent over the stovetop and oven had grease build up on the filters under the vent hood and grease on the outer surface of the hood with pooled streaks of grease visible. The vent hood had a sticker on it indicating the hood and vent had last been cleaned in December 2018, and was scheduled for another cleaning in June 2019. Dietary Staff #1 stated "I see the grease marks on the vent hood as well as the grease build up on the filters." - The inside of the oven had a build up of food particles on the floor of the oven. Dietary Staff #1 agreed there was "a lot of spilled food build up in the bottom part of the oven". Review of facility's document titled, "Kitchen Cleaning Schedule", revealed no specific person for cleaning, but rather cleaning was assigned to the AM (morning) Cook, AM (morning) Tray Person, Prep Cook, PM (Evening) Cook, PM (Evening) Tray Person, and Storage Person. The cleaning of the toaster, mixer, food warmer, or	F 812	filters and food warmer to ensure the cleanliness of the kitchen department is maintained. Weekly inspections will be conducted beginning on June 10, 2019, and ending on July 5, 2019. A log of findings will be maintained. Any problems identified will be reported to the Administrator for corrective action if needed. 4)Findings will be reviewed by the Quality Assurance Committee and the Medical Director quarterly to ensure compliance is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 812	Continued From page 23 vent hood were not specified, and did not have a person assigned. The cleaning of the stove was assigned to the Prep Cook. An interview, on 4/30/19 at 9:35 AM, with Dietary Staff #1, revealed the equipment was supposed to be wiped down in the evenings after meal service was completed, but it was not clean, indicating it had not been done. Dietary Staff #1 stated the toaster was used that morning, but the build up present appeared to be from a couple of days of not being cleaned. Dietary Staff #1 stated, "the mixer was used yesterday afternoon, but it's still dirty, and the food warmer has dried food on the lip and just inside the door". Dietary Staff #1 stated, "I can see the grease on the oven vent and a build up on the filters too. The oven has build up in the bottom of it. It was dried and black in color." In an interview, on 4/30/19 at 12:40 PM, with the Dietary Manager (DM), he stated, "I was told when I got here today that you had found the toaster, mixer and other equipment dirty, but they are clean now. I do see grease on the vent hood, and the filters under the vent hood does have grease build-up on it. I am going to call the company and get them to come clean the the vent hood today. " The DM stated the facility used a cleaning schedule as a guide for cleaning. A review of the cleaning schedule posted in the kitchen, and provided by the Dietary Manager revealed assignments made to the AM Cook, AM Tray Person, Prep Cook, PM Cook, PM Tray Person, and Storage Person did not include the items found unclean, other than the oven which was assigned to the Prep Cook. The DM stated, "the person who uses the equipment last is supposed to clean it." The DM verified there was	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 812	Continued From page 24 no specific assignment of staff, and the items found not cleaned were not listed on the cleaning schedule. The DM stated, "I can see we need a more detailed list." An interview, on 5/02/19 at 9:14 AM, with the facility's Administrator, revealed the Dietary Manager usually stayed on top of the cleaning in the kitchen. He was unsure what happened. The Administrator stated the facility should create a more detailed cleaning schedule in order to hold staff accountable.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING **01 - GEORGE REGIONAL HEALTH AND REHABILITATION** B. WING _____	**05/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	**859 WINTER ST** **LUCEDALE, MS 39452**

(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 meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 06/14/2019

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
	255333	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

(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 * EMERGENCY PREPAREDNESS * Survey conducted on 5/1/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 06/14/2019

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.