STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. BUILDING _____ B. WING _____	10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE LEAKESVILLE, MS 39451

(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 A COVID-19 Focused Infection Control Survey along with a complaint investigation (CI MS #16713, CI MS #16824, CI MS #16848, CI MS #16857, CI MS #16989, CI MS #17025) was conducted by the State Agency (SA) on 10/12/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. At the time of the survey, the facility had a census of 39 and held a license for 60 beds. CI MS #16713 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to No Pressure Sore Precautions and Inappropriate Feeding Assistance. CI MS #16824 The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect, Quality of Care related to Facility Staffing, Resident Meds Not Given According to Physicians Orders, Residents Not Groomed Adequately and, Dietary Services related to Meals Not Served Timely. CI MS #16848 The result of the investigation was unsubstantiated with no deficiencies cited for Misappropriation of Property. CI MS #16857 The result of the investigation was	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. BUILDING _____ B. WING _____	10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	**1300 MELODY LANE LEAKESVILLE, MS 39451**

(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	Continued From page 1 unsubstantiated with no deficiencies cited for Quality of Care related to Client Services not Performed Per Physicians Order and Rehabilitation Services. CI MS #16989 The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect related to Pressure Sore and Quality of Care related to Care/Services not Received Per Physicians Order. CI MS #17025 The result of the investigation was unsubstantiated with no deficiencies cited for Admission, Transfer, Discharge and Resident Abuse..	F 000		