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 _____	11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE/PO BOX 640 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 State Survey Agency (SA) conducted an annual recertification survey at the facility from 11/7/18 to 11/9/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited regulatory deficiencies at F658, F758 and F880. The census at the time of the survey was 58, and the facility was certified for 60 beds.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to follow the physician's order for a follow up Urinalysis with a Culture and Sensitivity (UA C&S), due to a recent Urinary Tract Infection (UTI) with treatment, for Resident #38. This concern was identified for one (1) of three (3) residents reviewed for UTIs. Findings include: A review of the facility's "Cultures" policy, dated June 2017, revealed: "when cultures are ordered, they should be obtained and completed as soon as practical." Review of the Mississippi Nursing Practice Law,	F 658	1. On 11.08.18 The Resident Care Manager (RCM) identified Resident #38 and reviewed the physician orders pertaining to lab to be drawn or collected. The Resident Care Manager notified Resident #38's provider of the incomplete lab order. The provider gave a telephone order for Urinalysis with Culture and Sensitivity in the A.M. The Resident Care Manager noted the order, completed all required lab request and notified Resident's Cart Nurse. On 11.09.18 the Resident Care Manager reviewed the resident's chart and lab request sheets to ensure the specimen had been collected and sent to lab.	12/9/18

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

Electronically Signed | 11/30/2018

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F 658	Continued From page 1 with an effective date of July 1, 2010, revealed on pages three and four (3 & 4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Record review of Resident #38's Physician's	F 658	2. All residents have the potential to be affected by this deficient practice. Starting on 11.08.18 and completed on 11.12.18 the Director of Nursing and RN Risk Manager conducted a 100% audit of all residents physician orders pertaining to lab orders to ensure completion of the order. Any needed corrections were made at the time of audit. 3. The facility through the Quality Assurance Committee has implemented a Lab Tracking Tool. The Lab Tracking Tool includes date of order, residents name, lab ordered, STAT or Routine, and date of draw. Registered or Licensed Practical Nurse receiving the order for lab will complete date of order, residents name, lab ordered. STAT or Routine. The Resident Care Manager will review the Lab Tracking Tool on a daily basis and confirm all ordered labs have been completed. The Registered Nurse (RN) Risk Manager will audit the Lab Tracking Tool on a weekly basis for eight (8) weeks and then monthly to ensure all lab is complete. Starting 11.08.18 and completed on 11.30.18 The RN Risk Manager conducted in-service for all Registered and Licensed Practical Nurses. The in-service included ensuring physician order are followed related to drawing lab are complete for each resident, and the facility's Lab Tracking Tool. 4. The results of the weekly and monthly audits will be presented to the Quality Assurance Committee by the RN Risk	

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F 658	Continued From page 2 Telephone Orders revealed an order, dated 10/30/18 and 11/1/18 to obtain a UA C&S. The order on 11/1/8 included an order to obtain a Stool C&S. Review of Resident #38's Laboratory Reports revealed the Stool C&S was completed, and was negative. Further review of the reports revealed no results or reports for the UA C&S. The Laboratory Reports revealed a UA, dated 10/16/18 was completed. Hand written on the report was an order for Rocephin one gram (1 GM.) intramuscularly (IM) X (times) three (3) days for UTI, wait for C&S. The Laboratory Reports also revealed the UA C&S final report, dated 10/18/18, indicated a UTI with greater than 100,000 CFU/ML (Colony Formed Unit per Milliliter) Escherichia coli. Resident #38 was treated for the UTI. On 11/09/18 at 9:31 AM, an attempt to call (Licensed Practical Nurse) LPN #3 was unsuccessful. LPN #3 was the 11-7 shift nurse that was working the night the U/A was to be collected. LPN #3 left a statement with LPN #1. Review of LPN #3's handwritten statement revealed: "On 10/31/8 at 5:20 AM this nurse was unable to obtain urine specimen on (Name of Resident #38) due to resident yelling out and pushing nurse away. An attempt to interview LPN #3 was unsuccessful related to she did not answer the surveyor's call at the number on the facility's contact list after two attempts. A record review of the Nurses Notes revealed there was no documentation of the resident's refusal of a U/A until 11/8/18.	F 658	Manager or Director of Nursing. The Quality Assurance Committee will evaluate and monitor the corrective action for substantial compliance. The Quality Assurance Committee will make any changes necessary to ensure substantial compliance is achieved and maintained. The Quality Assurance Committee consist but not limited to the Medical Director, Administrator, Director of Nursing, and at least two (2) other facility staff. The Quality Assurance Committee meets at least quarterly or more often as needed.	

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F 658	Continued From page 3 Review of the hospital Laboratory Reports for Tests Ordered, dated 11/8/18, and with the collected date of 11/1/18, revealed no specimen was received. Review of the Resident #38's Physician's Telephone Orders revealed an order, dated 11/8/18, to obtain a UA C&S now. Review of the Laboratory Reports revealed the UA C&S was collected on 11/9/18. Hand written on the UA report was, notified (Name of Nurse Practitioner/NP) and an order for Cipro 500 mg. (milligrams) by mouth twice a day for a UTI, notify (Name of NP) when culture received. On 11/07/18 at 4:55 PM, a telephone interview with Resident #38's nephew revealed the resident has had several UTIs recently. The resident's nephew reported that most of them were when he was in the hospital, and being catheterized often. An interview on 11/08/18 at 4:47 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #38's chart does not have any results for the U/A ordered on 11/1/18. LPN #1 reported she had called three (3) different laboratories (labs), and no one had a urine sample for 11/1/18 for this resident. LPN #1 reported that she knew Resident #38 refused sometimes, but she does not see that in the documentation. On 11/8/18 at 5:04 PM, an interview with LPN #2, revealed the lab technician usually documents if the resident refuses to do a lab. LPN #2 reported she does not see where the resident had refused the U/A in the resident's chart. On 11/09/18 at 9:11 AM, an interview with LPN#1	F 658		

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F 658	Continued From page 4 revealed the staff attempted to collect the urine last night without success, but they were able to get it this AM. LPN #1 reported the nurse that was working the night the U/A was ordered was unable to obtain the U/A, but did not chart it. On 11/09/18 at 9:21 AM, an interview with the Director of Nursing (DON) revealed Resident #38 did not get his U/A on 11/1/18 as ordered. The DON reported that her staff told her the resident refused. The DON reported Resident #38 refused care intermittently. The DON reported she would expect if he refused a U/A that it would be documented in the chart, and that the Physician would be notified. A review of the facility's Face Sheet for Resident #38, revealed the facility admitted the resident, on 7/18/18, with the included diagnoses Down's Syndrome, Enterocolitis Due To Clostridium Difficile, and Hypothyroidism. Review of Resident #38's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/18, revealed a Basic Interview for Mental Status (BIMS) score was 2, which indicated severe cognitive impairment. Resident #38 was always incontinent of bowel and bladder, was coded for a UTI in the past 30 days.	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		12/9/18

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F 758	Continued From page 5 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 6 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review and staff interview, the facility failed to complete a Gradual Dose Reduction (GDR) for Resident #40's psychotropic medication for Depression, for one (1) of five (5) residents reviewed for GDR. Findings include: A review of the facility's "Tapering Medication and Gradual Dose Reduction" policy, dated April 2007, revealed that if a resident is initiated on a psychopharmacological medication, "the facility will attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated." Record review of Resident #40's November 2018 Physician's Orders revealed an order, dated 6/15/17 for Citalopram HBR 10 mg. (milligram) tablet by mouth daily for Depression. Review of the facility's Psychotropic and Sedative/Hypnotic Utilization By Resident revealed Resident #40 did not have a GDR for the Citalopram. The column designated for the last GDR for the Citalopram was blank. An interview, on 11/08/18 at 10:50 AM, with the Director of Nursing (DON) revealed the Pharmacist comes monthly and reviews the	F 758	1. On 11.09.18 the Registered Nurse (RN) Risk Manager identified Resident #40 and confirmed an order for Citalopram HBR 10 mg (milligrams). The RN Risk Manager then reviewed physician orders , physician notes and pharmacy recommendation to ensure that a Gradual Dose Reduction was completed or if there was a clinical reason for not attempting a Gradual Dose Reduction. The RN Risk Manager contacted Resident #40's provider and reported the findings of the review. On 11.12.18 the provider entered a note into Resident #40"s medical record stating resident has extensive psychiatric history and the benefits of prescribed antidepressants out weighs the potential risk at this time. I do not agree with any pharmacy recommendations for a Gradual Dose Reductions at this time. 2. All residents that are taking psychotropic medications have the potential to be affected by the deficient practice. Starting on 11.09.18 and completed on 11.28.18, the Director of Nursing, RN Risk Manager and Pharmacy Consultant conducted a 100% audit resident medication orders to identify psychotropic drug orders. There were no negative finds identified during the audit. 3. The facility through the Quality	

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F 758	Continued From page 7 charts monthly. The DON reported they have a meeting quarterly with the Pharmacist, DON, and the Social Worker to discuss the GDRs, medications, behaviors and side effects. The DON reported they review all of the residents at this meeting. The DON reported they are trying to track the psychotropic medications, and make sure they are being reviewed according to the regulations. On 11/08/18 at 12:16 PM, an interview with the Administrator revealed they changed pharmacy consultants about four months ago. On 11/08/18 at 12:36 PM, an interview with the DON revealed the GDR was not done on the Citalopram for Resident #40. The DON reported she expected that GDRs be completed to follow the regulation. On 11/08/18 at 4:28 PM, the DON reported the Pharmacy Consultant is out of the office until November 16, so she was unable to be interviewed. Review of the Consultant Pharmacist's Automatic Reply email revealed the Pharmacist was going to be out of the office from November 6, 2018 to November 15, 2018. A review of the facility's Face Sheet, for Resident #40, revealed the facility admitted the resident, on 3/2/17, with the included diagnoses Spinal Bifida, Alzheimer's disease, and Urinary Tract Infection. Review of Resident #40's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/26/18, revealed a Basic Interview for Mental Status (BIMS) score of 11,	F 758	Assurance Committee has implemented a Medication review for Gradual Dose Reductions. The Medication review for Gradual Dose Reduction form will be completed by facility's Person's At Risk Team for Behavior Management. The form includes resident's name, medication, dosage, order date, stop date, gradual dose reduction date, and review date. The Patient At Risk Behavior Monitor Team consist of Director of Nursing, Resident Care Manager and two (2) other nursing staff members. The Patient At Risk Behavior Management Team meets on a weekly basis.The RN Risk Manager will audit the Residents receiving psychotropic drugs using the Gradual Dose Reduction Form on a weekly basis for eight (8) weeks and then monthly. 4. The results of the weekly and monthly audits will be presented to the Quality Assurance Committee by the RN Risk Manager or Director of Nursing. The Quality Assurance Committee will evaluate and monitor the corrective action for substantial compliance. The Quality Assurance Committee will make any changes necessary to ensure substantial compliance is achieved and maintained. The Quality Assurance Committee consist but not limited to the Medical Director, Administrator, Director of Nursing, and at least two (2) other facility staff. The Quality Assurance Committee meets at least quarterly or more often as needed.	

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F 758	Continued From page 8 which indicated mild cognitive impairment. Resident #49 was coded for a an Active Diagnosis of Depression, and had received an antidepressant medication for seven of the seven (7 of 7) look back days.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		12/9/18

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F 880	Continued From page 9 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to prevent the possibility of infection as evidenced by failure to change/discard contaminated oxygen (O2) tubing	F 880	1. 11.07.18 The Registered Nurse (RN) Risk Manager identified Resident # 10, RN #1 Staff Development Nurse, and the nasal cannula oxygen tubing. On 11.07.18	

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F 880	Continued From page 10 for one (1) of 12 resident's reviewed, Resident #10. Findings include: Upon request the facility failed to provide an infection control policy that addressed this infection control concern. A review of Resident #10's medical records, titled "Physician Orders", dated November 2018, revealed a physician's order dated, 10/22/2018, for Oxygen (O2) at two (2) liters per nasal cannula (N/C), as needed (PRN). The physician's orders for Resident #10 also stated this was to keep Resident #10's O2 saturation above 93 percent (%). An observation, on 11/07/2018 at 11:38 AM, revealed upon entering Resident #10's room, there was a nasal cannula oxygen tubing connected to an oxygen concentrator, lying across the floor. Resident #10 was not present in the room at this time. While in Resident #10's room, Registered Nurse (RN) #1/Staff Development Nurse, entered the room. RN #1 picked up the nasal cannula oxygen tubing off of the floor, and laid the tubing on top of the oxygen concentrator next to Resident #10's bed. Before exiting Resident #10's room, an observation revealed a sticker on the O2 tubing that indicated it was "Due to be changed on 11/13/2018." An observation, on 11/07/2018 at 4:40 PM, revealed Resident #10 was sitting on the side of her bed. Resident #10 was wearing the nasal cannula oxygen tubing with the sticker that indicated it was "Due to be changed 11/13/2018."	F 880	the RN Risk Manager in-serviced RN#1 Staff Development Nurse on Infection Control pertaining to oxygen tubing, date, labeled proper storage and replacing weekly and as needed. The RN Risk Manager assisted RN#1 Staff Development Nurse with replacing Resident #10's nasal cannula oxygen tubing at approximately 02:00 PM on 11.07.18. 2. All resident requiring the use of oxygen has the potential to be affected by this deficient practice. The RN Risk Manager started on 11.07.18 and completed on 11.12.18 a 100% audit of 12 of 47 Residents requiring the use of oxygen. The audit included physician order and observing date, initials, and proper storage of oxygen tubing. 3. The RN Risk Manager will do weekly audits of all residents requiring oxygen for eight (8) weeks to ensure, date, initials, and proper storage. After eight (8) weeks, the RN Risk Manager will then conduct monthly audits. Starting on 11.07.18 and concluding on 11.30.18, RN Risk Manager conducted an in-service for all staff members on infection control including date, initials,proper storage and replacing weekly and as needed. 4. The results of the weekly and monthly audits will be presented to the Quality Assurance Committee by the RN Risk Manager, or Director of Nursing. The Quality Assurance Committee will make any changes necessary to ensure	

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 _____	11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE/PO BOX 640 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 880	Continued From page 11 During an interview, on 11/07/2018 at 4:55 PM, with RN #1, it was confirmed she had picked up the O2 tubing from the floor, and placed it on top of the O2 concentrator, next to Resident # 10's bed. RN #1 stated she should have removed the contaminated oxygen tubing, and replaced it with a new oxygen tubing. RN #1 stated, "That is an infection control problem." RN #1 also stated the tubing is changed weekly on Tuesdays. During an interview, on 11/09/2018 at 11:25 AM, with the Director of Nursing (DON), it was confirmed that not changing the tubing after finding it on the floor, was an infection control concern. The DON stated RN #1 should have disconnected the oxygen tubing, and discarded the tubing in the garbage. The DON stated RN #1 should have immediately changed it out. Review of the Face Sheet, for Resident #10 ,revealed the resident was admitted by the facility, on 02/10/2014, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Type 2 Diabetes Mellitus.	F 880	substantial compliance is achieved and maintained and any recommendation as needed. The Quality Quarterly Committee meets at least quarterly or more often as needed. The Quality Assurance Committee consists but is not limited to the Medical Director, Administrator, Director of Nursing, and at least two (2) other facility staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	**1300 MELODY LANE/PO BOX 640** **LEAKESVILLE, MS 39451**

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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 | 11/30/2018

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
	255179	A. BUILDING _____ B. WING _____	11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE/PO BOX 640 LEAKESVILLE, MS 39451

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 11/9/18 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 | 11/30/2018

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.