STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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 12/26/18 through 12/28/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F656, F690 and F791. The facility was licensed for 120 beds and had a census of 104 at the time of survey	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		1/18/19

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

Electronically Signed | 02/13/2019

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.

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F 656	Continued From page 1 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 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 staff interview, record review and facility policy review, the facility failed to follow the care plan related to catheter care for (2) of (3) catheter care observations, for Residents #39, and #48 Findings include: Review of the facility's, "Comprehensive Care Plan Policy", revised 12/2016, revealed a comprehensive, person-centered, care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment. The interdisciplinary	F 656	1. Certified Nursing Assistant (C.N.A)#2 received one to one education on December 27, 2018 from the Staff Development Coordinator on requirements of catheter care performance and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. On December 27, 2018 C.N.A. #1 received one to one training rom (SDC) on catheter care performance and failure to prevent recontamination by wiping front to back and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. Resident #48 and #39 were assessed by the Nurse Practitioner (NP) on 12/28/2018; no issues identified. 2. All residents have the potential to be affected. On December 28, 2018 an audit	

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F 656	Continued From page 2 team includes a nurse aide who has responsibility for the resident. Review of Resident #39's Care Plan revealed a Focus for alteration in elimination as evidenced by an indwelling Foley catheter with an initial date was 02/06/2018. The Goals included the resident would be free from signs and symptoms (s/s) of infection during this 90 day review period. The target date was 02/06/2019. The Interventions included: Foley catheter (cath) care every (Q) shift and as needed (PRN) every shift for cath care. During Resident #39's catheter care observation, on 12/27/18 at 10:46 AM, Certified Nursing Assistant (CNA) #2 failed to secure the catheter near the entrance of meatus to prevent possible trauma. CNA #2 pulled the tubing outward from the meatus with a wet wipe. During an interview, on 12/28//2818 at 1:33 PM, Care Plan Nurse/ Registered Nurse (RN) #1 revealed she expected the CNAs to follow professional standards while providing care. RN #1 confirmed the CNAs failed to follow the care plan by not securing the tubing while providing the catheter/peri care. During an interview, on 12/28/18 at 2:37 PM, CNA #2 confirmed she failed to secure the tubing near the meatus. CNA #2 stated she was nervous, and forgot. A review of the Face Sheet revealed Resident #39 was admitted by the facility, on 07/27/2018, with diagnoses which included Pressure Ulcer of Right Buttocks, Acute Cystitis with Hematuria and Acute Kidney Failure.	F 656	of residents with catheters was initiated by the Director of Nursing (DON) and Assistant Director of Nurses to ensure no negative issues related to catheter care; no negative issues identified. 3. On December 28, 2018 return demonstrations were initiated and are ongoing for Certified Nursing Assistants to include cleaning and securing of catheter tubing, by Staff Development Coordinator. On February 19, 2019 Information Quality Healthcare, RN (IQH representative) will conduct education on catheter care procedures and goals to prevent trauma and/or infection with nursing staff. Nursing and CNA staff were in-serviced on December 31, 2018 by Staff Development Coordinator regarding peri care, catheter care, anchoring of tubing,dental care of residents and residents rights. 4. Beginning the week of December 31, 2018, audits of catheter care observations will be conducted by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or supervisor to ensure the catheter care is completed accurately by return demonstration of all of the C.N.A.s performance of catheter care following regulatory guidelines. Audits/observations will be conducted weekly times four (4) weeks then monthly times two (2) months, then quarterly thereafter. Negative findings of the return demonstrations will be addressed immediately and a performance improvements plan implemented. A report	

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F 656	Continued From page 3 A review of Resident #39's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2018, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was mildly cognitively impaired. Resident #48 Review of Resident #48's Care Plan revealed a Focus for alteration in elimination as evidenced by an indwelling Foley catheter with an initial date of 08/01/2017. The Goals included the resident would be free from s/s of infection duriing this 90 day review period. The Target date was 02/12/2019. Interventions included provide catheter care every shift and as needed. During an observation of Resident #48's catheter/pericare provided by CNA #1, on 12/27/18 at 1:24 PM, CNA #1 took a wet wipe, and failed to clean from front to back. CNA #1 cleaned the peri area in a circular motion which caused contamination to the clean areas over the peri area. CNA #1 also failed to secure the tubing at the entrance of the meatus while cleaning the catheter tubing. CNA #1 grabbed the tubing at the meatus, and pulled it outward. During an interview, on 12/28//2818 at 1:33 PM, the Care Plan Nurse/RN #1 revealed she expected the CNAs to follow the professional standards while providing care. RN #1 confirmed the CNAs failed to follow the care plan by not cleaning from front to back, and not securing the tubing while providing catheter/peri care. During an interview, on 12/27/18 at 2:59 PM, CNA	F 656	of audits will be brought to the Monthly Quality Assurance Performance Improvement committee, monthly times three months for further recommendations by the Director of Nursing. The Director of Nursing is responsible for monitoring and compliance.	

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F 656	Continued From page 4 #1 confirmed she failed to clean from front to back. CNA #1 stated she was nervous, and could not think straight. CNA #1 said she was trained to wipe from front to back. CNA #1 also said she was trained to secure the tubing prior to cleaning it to prevent the catheter from coming out. CNA #1 stated the resident could receive an infection by not wiping front to back. A review of the Face Sheet revealed Resident #48 was admitted by the facility, on 05/13/1916, with diagnoses which included Pressure Ulcer of Sacrum, Urinary Tract Infection. A review of Resident #48's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2018, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was mildly cognitively impaired.	F 656		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		1/18/19

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F 690	Continued From page 5 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide catheter care in manner to prevent trauma to the meatus, and a Urinary Tract Infection (UTI) for two of three catheter care observations, for Residents #39 and #48. Findings Include: A Review of the facility's policy titled, "Catheter Care, Urinary" revealed the purpose of this procedure is to prevent infection of the resident's urinary tract. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. For the female: Use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the	F 690	1. Certified Nursing Assistant (C.N.A)#2 received one to one education on December 27, 2018 from the Staff Development Coordinator on requirements of catheter care performance and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. On December 27, 2018 C.N.A. #1 received one to one training rom (SDC) on catheter care performance and failure to prevent recontamination by wiping front to back and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. Resident #48 and #39 were assessed by the Nurse Practitioner (NP) on 12/28/2018; no	

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F 690	Continued From page 6 position of the washcloth with each downward stroke. Next, change the position of the wash cloth and cleanse around the urethral meatus. Do not allow the wash cloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique. Use a clean wash cloth with the warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. A Review of the facility's inservice titled, State Readiness: handwashing, pericare, foley ,ADLs (Activities of Daily Living) and abuse revealed CNA #1 and CNA #2 were trained how to provide catheter care in a manner to prevent trauma to the meatus and infection to the urinary tract. Resident #39 During Resident #39's catheter care observation, on 12/27/18 at 10:46 AM, Certified Nursing Assistant (CNA) #2 failed to secure the the catheter tube at the meatus insertion site to prevent possible trauma. CNA #2 pulled the catheter tubing outward from the meatus with a wet wipe. During an interview, on 12/27/18 at 2:09 PM, Licensed Practical Nurse (LPN) #2/Staff Development Nurse confirmed the facility failed to provide catheter care according to the facility policy. LPN #2 also stated the CNAs secure the catheter tubing near the meatus to prevent trauma and to keep the catheter from coming out. During an interview, on 12/28/18 at 2:37 PM, CNA #2 confirmed she failed to secure the catheter tubing near the meatus. CNA #2 stated she was nervous and forgot.	F 690	issues identified. 2. All residents have the potential to be affected. On December 28, 2018 an audit of residents with catheters was initiated by the Director of Nursing (DON) and Assistant Director of Nurses to ensure no negative issues related to catheter care; no negative issues identified. 3. On December 28, 2018 return demonstrations were initiated and are ongoing for Certified Nursing Assistants to include cleaning and securing of catheter tubing, by Staff Development Coordinator. On February 19, 2019 Information Quality Healthcare, RN (IQH representative) will conduct education on catheter care procedures and goals to prevent trauma and/or infection with nursing staff. Nursing and CNA staff were in-serviced on December 31, 2018 by Staff Development Coordinator regarding peri care, catheter care, anchoring of tubing,dental care of residents and residents rights. 4. Beginning the week of December 31, 2018, audits of catheter care observations will be conducted by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or supervisor to ensure the catheter care is completed accurately by return demonstration of all of the C.N.A.s performance of catheter care following regulatory guidelines. Audits/observations will be conducted weekly times four (4) weeks then monthly times two (2) months, then quarterly	

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F 690	Continued From page 7 Review of the Face Sheet revealed Resident #39 was admitted by the facility, on 07/27/2018, with diagnoses which included Pressure Ulcer of Right Buttocks, Acute Cystitis with Hematuria and Acute Kidney Failure. Review of Resident #39's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2018, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was mildly cognitively impaired. Resident #48 During an observation, on 12/27/18 at 1:24 PM, CNA #1 provided Resident #48's catheter/pericare. CNA #1 took a wet wipe and failed to clean from front to back. CNA #1 cleaned the peri area in a circular motion contaminating the cleaned peri area. CNA #1 also failed to secure the catheter tubing at the meatus insertion site while cleaning the catheter tubing. CNA #1 grabbed the tubing at the meatus and pulled the catheter tube outward. During an interview, on 12/27/18 at 2:59 PM, CNA #1 confirmed she failed to clean from front to back. CNA #1 stated she was nervous and could not think straight. CNA #1 said she was trained to wipe from front to back. CNA #1 also said she was trained to secure the tubing prior to cleaning it to prevent the catheter from coming out. CNA #1 stated the resident could receive an infection by not wiping front to back. During an interview, on 12/27/18 at 2:09 PM, LPN #2 confirmed the facility failed to provide catheter	F 690	thereafter. Negative findings of the return demonstrations will be addressed immediately and a performance improvements plan implemented. A report of audits will be brought to the Monthly Quality Assurance Performance Improvement committee, monthly times three months for further recommendations by the Director of Nursing. The Director of Nursing is responsible for monitoring and compliance.	

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F 690	Continued From page 8 care according to the facility policy. LPN #2 also stated the CNAs should clean from front to back, and secure the catheter tubing near the meatus to prevent trauma and the catheter from coming out and prevent infection. A review of the Face Sheet revealed Resident #49 was admitted by the facility, on 05/13/1916, with diagnoses which included Pressure Ulcer of Sacrum, , Urinary Tract Infection. A review of Resident #48's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2018, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was mildly cognitively impaired..	F 690		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the	F 791		1/18/19

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F 791	Continued From page 9 dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received routine dental services for one (1) of 22 residents interviewed regarding dental services, for Resident #63 Findings Include: The facility did not provide any policy related to obtaining dental services for residents. An observation and interview, on 12/26/18 at 3:49 PM, with Resident #63 revealed the resident had several teeth missing, and existing teeth were	F 791	1. Resident #63 was assessed for dental concerns by Nurse Practitioner on 12/28/2018; no issues were identified. Resident #63 was offered dental services in house and/or facility would arrange for an appointment and provide transportation; resident declined dental services. Care plan was reviewed by Minimum Data Set nurse (MDS) on 12/28/2018 and revised to indicate resident's preferences. 2. On January 5, 2019, an audit was conducted with 110 residents by the Director of Nurses(DON), Assistant	

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F 791	Continued From page 10 dark and stained. Resident # 63 stated she didn't remember when she'd seen the dentist, but thought she had. Resident #63 stated she has not had any problems eating or chewing, but did think she should see the dentist. A review of Resident # 63's Progress Noted, Title: Limited Oral Examination revealed a dental exam, dated 06/07/17, indicating the resident had loose teeth, and partial endentulism. The Plan was to re-evaluate and monitor for bone levels and loose tooth/teeth during the next scheduled visit with a recommendation to continue daily oral care. Review of Resident #63's chart revealed no indication that there had been any further visits scheduled or completed since 06/07/17. A review of Resident # 63's most recent Annual Minimum Data Set (MDS) and Quarterly MDS assessment, with assessment reference dates of 08/25/18 and 11/17/18, revealed the resident was assessed to not have any issue with swallowing or eating, and the resident was assessed to not have any issues with teeth including no loose or broken teeth. An interview, on 12/27/18 at 5:21 PM, with RN #1, revealed there was a time a dentist came to the facility for services, but there had not been one come to the facility recently. RN #1 stated if a resident needed dental services, the facility would arrange for an appointment, and take the resident to the appointment. When asked about when residents were referred to a dentist, RN #1 stated they would be seen if they complained of tooth pain, or were assessed by the physician, nurse practitioner, or nurses to have any tooth or eating issues.	F 791	Director of Nurses, and Social Service Director to ensure residents were offered and/or provided dental services, for minimum but not limited to, annual evaluations. Residents identified with dental service needs and upon resident agreement had appointments scheduled with facility arrangement of transportation as indicated. Residents who declined dental services received education with documentation of residents in the nurses' notes and care plans are being updated to indicate resident's preferences by Minimum Data Sets. Residents with BIMS lower than 10 were assessed by Director of Nurses (DON) and Assistant Director of Nurses on January 5, 2019 and Responsible Parties were contacted or for issues with swallowing or eating and for evidence of loose or broken teeth; no issues noted. 3. On February 19, 2019 Information Quality Healthcare, RN (IQH representative) will conduct education on requirements for annual dental examinations with replacement of any lost or stolen dentures. Staff was educated on December 31, 2018 and ongoing by Staff Development Coordinator to report any issues with dentures to social services/Nursing Staff. Residents will be asked on admission when is the last time they have seen dentist and appointments will be made upon requests/identified needs. 4. Beginning the week of December 31, 2018, audits will be conducted by Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

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F 791	Continued From page 11 An interview, on 12/28/18 at 8:56 AM, with the Assistant Director of Nursing (ADON) regarding how residents were assessed for dental services revealed the facility used to have a dentist come in, but no longer did. The ADON was not sure how long it has been since there had been a dentist to provide services in the facility, but he hadn't recently. The ADON stated nurses should assess the residents for tooth/mouth problems and discuss any problems at the quarterly review of the care plan. A review of the Resident #63's comprehensive care plan revealed the resident did not have a care plan addressing dental care. An interview, on 12/28/18 at 9:10 AM, with the Administrator regarding dental services revealed the facility did not have a dentist who came to the facility, but had one in the past. The Administrator stated the facility would utilize a local dentist when residents needed services. The Administrator stated she would make an effort to secure dental services for residents who don't want to go out. An interview, on 12/28/18 at 9:12 AM, with RN #1 revealed Resident #63 had anxiety, and did not like to leave the facility, so she probably wouldn't go if an appointment had been scheduled. An interview, on 12/28/18 at 9:18 AM, with RN #1 revealed she had spoken to the resident, and the resident stated she did not want to leave the facility for a dental exam. She had not asked the resident prior to this date. An interview, on 12/28/18 at 10:55 AM, with RN	F 791	Service Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Supervisor to ensure that residents are offered or receiving annual dental services for new admissions or transfers. Current residents will be assessed/interviewed on quarterly basis to determine if dental services are needed/desired. Social Services and/or Supervisor to address any lost or damaged dentures within three (3) days by providing dental services appointment with transportation arrangements and/or assessment with documentation to ensure resident has no loose or broken teeth which will result in swallowing or eating difficulties following regulatory guidelines. These audits will occur weekly times four (4) weeks then monthly times (2) months, then quarterly thereafter. The findings of the audits will be addressed immediately and a performance improvement plan will be reviewed with the Quality Assurance Performance Improvement committee, monthly times three months for further recommendation. The Director of Nursing is responsible for monitoring and compliance.	

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	255141	A. BUILDING _____ B. WING _____	12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

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F 791	Continued From page 12 #2 revealed Resident #63 liked to stay in her room due to problems with anxiety, and it was RN,#2's opinion that Resident # 63 would not be willing to go out of the facility for appointments. RN #2 stated the resident had not complained of any dental problems, but would definitely have to see a dentist in the facility because of her anxiety. RN #2 stated the resident even refused to go for a cardiac evaluation due to her anxiety. A review of Resident # 63's Face Sheet revealed Resident #63 by the facility, on 11/18/15, with diagnoses including Anxiety Disorder, Dysphagia, and GERD. The facility did not provide any documentation of efforts made to secure a dentist for routine or emergency dental care for residents who did not wish to leave the facility for appointments.	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	**1620 READ ROAD** **PICAYUNE, MS 39466**

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K 000	INITIAL COMMENTS 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 | 02/14/2019

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
	255141	A. BUILDING _____ B. WING _____	12/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

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E 000	Initial Comments Survey conducted on 12/27/18 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

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