STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 09/23/2019 to 09/26/2019. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited regulatory deficiencies F550, F640, F641, F656, and F758. At the time of the survey, the census was 105 , and the facility held a license for 116 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		11/8/19

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

Electronically Signed | 10/19/2019

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility policy review, the facility failed to honor Resident #254's dignity and/or preferences to wear underwear instead of adult incontinent briefs. This concern was identified for one (1) of 29 residents observed. Findings include: Review of the facility's "Resident Rights Policy", dated November 2016, revealed it is the policy of this facility to provide services based on the following requirements: The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility will protect and promote the rights of the resident. Observations and interviews, on 09/24/19 at 3:41	F 550	F550 1. Resident #254 was provided a pair of underwear instead of a brief as requested on day of complaint. Resident has been discharged home on 10/18/2019 with no evidence of psychosocial harm. 2. All continent residents have the potential to be affected if they choose to wear underwear. 3. a. An in-service was provided on 9/30/19 by the Director of Nursing for nursing employees on Resident Rights and Dignity. b. The Resident Rights and Dignity Policy and Procedures were reviewed on 9/26/19 by the Administrator and Director of Nursing with no changes made. c. The Social Services Director will	

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F 550	Continued From page 2 PM, and 09/23/19 at 11:08 AM, revealed Resident #254 was wearing adult incontinent briefs. Resident #254 stated he knew when he needed to use the bathroom. An interview, with Resident #254, on 09/24/19 at 2:05 PM, revealed staff started putting a brief on him for bowel movements, then they said they were going to leave the brief on, and he could just use the brief if they couldn't get to him in time. Resident #254 stated he does call, but they don't come, so he has to use the brief. Resident #254 stated the staff has told him to use the "diaper" and they will come change him. Resident #254 stated he has a urinal, but he can't hold it and put it in place; but if they would place it, he can position it to use it. Review of Resident #254's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/19, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #254 was coded to be frequently incontinent of urine, and always incontinent of bowels. An interview, on 09/24/19 at 2:15 PM, revealed Licensed Practical Nurse (LPN) #1 stated Resident #254 had a urinal. LPN #1 also stated they don't have a bowel and bladder training program. On 9/24/19 at 2:24 PM, an interview with the Director of Nursing (DON) revealed she had talked with Resident #254 when he was admitted and was aware that he knew when he needed to go to the bathroom. The DON stated the resident wore a brief when he was admitted from the other	F 550	began audits on 10/18/19 of all continent residents with Brief Interview of Mental Status (BIMS) of 12-15 to ensure the residents choice of wearing underwear vs briefs. d. Social Services will update care plan to reflect resident choice. e. Director of Nurses will update Kiosks for each residents choice. f. Audit on resident choice will be done by the Lead Certified Nursing Assistant(LCNA)weekly for four weeks, then monthly for two months. 4. The Social Service Director and Director of Nursing will report findings of audits to the Quality Assurance Performance Improvement Committee monthly. Findings will be addressed with changes made as necessary to ensure continued compliance.	

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F 550	Continued From page 3 facility. The DON agreed this was not right. The DON stated she told the staff when he was admitted that he did not need to be in a brief. The DON stated she was not happy about this. She stated it was their job to promote independence. On 09/24/19 at 3:40 PM, an interview with Resident #254, in the presence of the DON, confirmed the resident's wishes not to wear the incontinent brief. On 09/26/19 at 10:00 AM, an interview with CNA # 1 revealed Resident #254 had a brief on when she made her rounds this morning. She stated he wanted his underwear on, so she changed him.	F 550		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		11/8/19

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F 640	Continued From page 4 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to transmit a Minimum Data Set (MDS) within 14 days of Resident #1's discharge from the facility, due to death. This affected one (1) of 29 residents reviewed, Resident #1. Findings include: Review of the facility's "Resident Assessment"	F 640	F640 1. Residents #1's Minimum Data Set (MDS) was closed and transmitted on 9/24/19 by the MDS Nurse. 2. All residents who are discharged from the facility have potential to be affected. 3. a. An in-service was done on 9/30/19 by the Director of Nursing for the	

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F 640	Continued From page 5 policy, not dated, revealed the Discharge Assessment is completed using the discharge date as the Assessment Reference Date (ARD). The Assessment must be completed within 14 days of the discharge date/ARD. Review of Resident #1's Discharge Assessment with Assessment Reference Date of 4/29/2019, was still open in the system. The MDS had not been signed off as completed or transmitted. The transmission report dated 5/3/2019, was reviewed without a record of the assessment found. Review of Resident #1's Departmental Notes, revealed Nursing Notes: Dated 04/29/19 at 4:04 AM, Resident #1 was found without vital signs (deceased). 04/29/19 at 4:05 AM, the Coroner and Hospice staff were in route. 04/29/19 at 7:00 AM, awaiting the funeral home to receive the body. Interview with the MDS Coordinator, on 09/24/2019 at 2:45 PM, revealed the Discharge Assessment was still open and had not been transmitted for Resident #1. She stated the MDS Coordinator at the time was no longer employed by the facility. She stated the MDS Coordinator usually checks to make sure all assessments are completed, signed and transmitted. She stated the MDS is important in this instance, for tracking information to be sent to Centers Of Medicare and Medicaid. Review of the Face Sheet revealed Resident #1 was admitted by the facility, on 12/07/18, with the included diagnoses: Anemia in Chronic Kidney Disease, Malignant Neoplasm of Colon, Dysphasia, and Diabetes.	F 640	MDS Nurse and the Registered Nurse Coordinator (RN)on transmitting and closing Minimum Data Set (MDS) within 14 days as required upon discharge due to death. MDS staff are now aware of how to check for open assessments prior to each transmission. b. The MDS Policy was reviewed on Transmission Procedures on 9/30/19 by the Director of Nursing with the MDS Nurse. No changes were made. c. The MDS Nurse, Registered Nurse (RN) Coordinator will audit all discharges due to death to ensure an MDS is submitted within 14 days as required. Audit will be done for four months beginning in October 2019. 4. The MDS Nurse, Registered Nurse (RN) Coordinator will report findings of audits to the Quality Assurance Performance Improvement Committee monthly. Findings will be addressed with changes made as necessary to ensure continued compliance.	

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F 641	Continued From page 6	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one (1) of 29 residents reviewed, Resident #52. Resident #52 received hospice services and the MDS did not reflect hospice. Findings include: Review of the facility's "Resident Assessment" policy, not dated, revealed: 3. The assessment will describe the resident's physical and mental deficits, strengths, and the requirements of assistance to meet his/her needs. The assessment will also identify risk factors associated with possible functional decline and describe the resident's objectives for maintaining or improving his/her functional abilities. Review of the Admission MDS, with an Assessment Reference Date (ARD) of 07/31/19, did not indicate that Resident #52 was on hospice. Review of the September 2019 Physician's Orders revealed Resident #52 was admitted to Hospice, on 07/25/19, due to Breast Cancer. On 09/24/19 at 4:32 PM, an interview with the Director of Nursing (DON) revealed the resident was admitted to the facility on Hospice and it	F 641	F641 1. Resident #52 had a Significant Correction Minimum Data Set (MDS) done on 9/24/19 by the MDS Nurse to include Hospice services. 2. a. All residents with Hospice services have the potential to be affected. 3. a. An in-service was done on 9/30/19 by the MDS Registered Nurse (RN) Coordinator on Significant Change assessments including Hospice Services on the MDS. b. The MDS Policy and Procedure was reviewed on 9/25/19 by the Director of Nursing with no changes. c. The MDS Registered Nurse (RN) Coordinator and the MDS Nurse will maintain a list of hospice residents and beginning in October will audit each other's MDS by reviewing Section O of the MDS to ensure Hospice Services are captured on the MDS as applicable monthly for four months. 4. The MDS Registered Nurse (RN) Coordinator will report findings of audits to the Quality Assurance Performance Improvement Committee monthly.	11/8/19

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F 641	Continued From page 7 should have been included on the admission MDS. On 09/25/19 at 1:53 PM, an interview with the MDS Coordinator revealed the failure to include Hospice on the MDS was an oversight on the staff's part. The MDS Coordinator stated the resident's assessment was completed and Hospice was noted on the assessment, but not entered on the MDS. The MDS Coordinator stated it was a matter of needing to be more careful and mindful of work.	F 641	Findings will be addressed with changes made as necessary to ensure continued compliance.	
F 656 SS=D	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	F 656		11/8/19

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F 656	Continued From page 8 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 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 record review, facility policy review, and staff interview, the facility failed to develop a care plan for Resident #69, related to a diagnosis of Urinary Tract Infection (UTI) and treatment, for one (1) of 29 residents reviewed. Findings include: Record review of the facility's "Comprehensive Resident Centered Care Plans" policy, not dated, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframe's to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable	F 656	F656 1. Resident #69's Care plan has been updated on 9/25/19 by the Medical Record's Nurse to include the diagnosis of Urinary Tract Infection (UTI) and treatment. 2. All Residents with Urinary Tract Infections (UTIs) have the potential to be affected. 3. a. An in-service was provided for licensed nursing staff on 10/15/19 by the Director of Nursing on the importance of updating the care plan for diagnosis and treatment of Urinary Tract Infections (UTI) b. The Care Plan Policy and Procedures were reviewed on 10/15/19 by the Director of Nursing with no changes.	

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F 656	Continued From page 9 physical, mental, and psychosocial well-being as required. Review of Resident # 69's comprehensive care plan revealed no problem was developed for Urinary Tract Infection or the antibiotic ordered and administered per intravenous (IV) route. Review of the nurse's notes revealed Resident #69 was transferred to the Emergency room (ER) on 09/10/19, and returned to facility on 09/13/19, with a diagnosis of UTI, with an order for an intravenous antibiotic Ceftriaxone 1 gram IV for seven (7) days, for Urinary Tract Infection. The completion of the antibiotic was on 09/20/19. Review of the Medication Administration Record revealed Ceftriaxone 1 gram IV for seven (7) days was administered from 09/13/19 to 09/20/19, for Urinary Tract Infection. On 09/24/19 at 3:15 PM, an interview with Registered Nurse (RN) #1 revealed she works part time and she does the care plans for new admits and with the Minimum Data Set assessments. RN #1 revealed she does not usually update the care plans on a daily basis. RN #1 revealed the unit nurse on the floor is responsible to make sure the care plans are updated. On 09/24/19 at 3:20 PM, an interview with RN #2 revealed she was the Unit Manager on the 2nd floor where Resident #69 resided. After she looked on the computer, in the chart, and in the care plan binder at the nurses station, RN #2 confirmed there was no care plan developed to address the hospital stay, the diagnosis of Urinary Tract Infection (UTI), and the order for the	F 656	c. A new Care Plan Registered Nurse (RN) has been hired to review, audit and correct resident records to ensure accuracy of each residents care plans. Audits will be done beginning on October for three months (3)to ensure care plans have been developed to reflect resident care. 4. a. The Director of Nurses will report findings of audits to the Quality Assurance Performance Improvement Committee monthly. Findings will be addressed with changes made as necessary to ensure continued compliance.	

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F 656	Continued From page 10	F 656		

intravenous antibiotic from the hospital. RN #2 revealed the nurse that re-admitted the resident to the facility should have updated and developed the care plan with the diagnosis of UTI, and the antibiotic ordered from the hospital, on discharge. RN #2 revealed the care plan should have included interventions for checking for signs and symptoms of UTI, checking for adverse side effects of the antibiotic, making sure the medication was administered as ordered, and performing proper peri-care.

On 09/24/19 at 3:35 PM, an interview with RN #3 revealed she was the Infection Control Nurse and she re-admitted Resident #69 to the facility after her hospital stay on 09/13/19. RN #3 confirmed she did not update the care plan with the Diagnosis of UTI and the order for intravenous antibiotics. RN #3 revealed she was admitting the resident, while she was training a new hire, and was doing other things and just did not place the new information on the care plan. RN #3 revealed it is important to make sure a new diagnosis and medications get put on the care plan.

On 09/24/19 at 3:45 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she was the Medical Records Nurse and confirmed no care plan was developed for Resident #69's UTI and the ordered antibiotic. LPN #1 revealed the nurse who writes the order should send the orders to the medical records office and she is not sure if the nurse sent the order for resident #69 after her hospital return, related to the antibiotic for a UTI for to her or not. LPN #1 revealed she does not remember that specific order.

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F 758	Continued From page 11	F 758		
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 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	F 758		11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

(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 758	Continued From page 12 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 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 staff interview, record review, and facility policy review, the facility failed to provide a stop date for an as needed (PRN) psychotropic medication for one (1) of 29 residents medications reviewed, Resident #96. Findings include: Review of the facility's "Unnecessary Drug Policy", dated November 2016, revealed as needed (PRN) orders for psychotropic drugs are limited to 14 days. 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. Record review revealed Resident #96 had an order, dated 08/26/19, for Ativan 0.5 milligrams (mg) by mouth (po) every 12 hours as needed for agitation and rest. The Ativan order did not have a stop date. An interview, on 09/24/19 at 2:47 PM, with the Director of Nursing (DON), revealed she was	F 758	F758 1. A stop date was added to Resident #96's psychotropic medication order by the Unit Manager on 10/8/2019. 2. All residents with orders for as needed (PRN) psychotropic medications have the potential to be affected. 3. a. The Psychotropic Medication Policy and Procedures was reviewed by the Director of Nursing on 9/27/19 with no changes. b. An in-service on as needed (PRN) psychotropic medications was done by the Director of Nursing on 10/15/19 for licensed nurses. c. The Director of Nursing will print and audit all (PRN) psychotropic medication orders to ensure a stop date is in place. Audits will be done weekly for two months. 4. a. The Director of Nursing will report findings of audits to the Quality	

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	255252	A. BUILDING _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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F 758	Continued From page 13 aware that psychotropic medications need a stop date. She stated the initial date should be 14 days after the order is written; then the resident should be re-evaluated and the doctor documents the rationale and further order in the progress note.	F 758	Assurance Performance Improvement Committee monthly. Findings will be addressed with changes made as necessary to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	**1221 EAST UNION STREET** **GREENVILLE, MS 38703**

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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 | 10/19/2019

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
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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/25/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 10/19/2019

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