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	255169	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey, at the facility, from 03/09/2020 to 03/12/2020. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F641, F645, F657, and F812. The census at time of survey was 69, and the facility held a license for 100 beds.	F 000		
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 code the Minimum Data Set (MDS) related to anticoagulants for one (1) of 22 resident MDS assessments reviewed, Resident #49. Findings include: Review of the facility's "Resident Minimum Data Set (MDS) Assessment" policy, with a revision date of 09/2019, revealed, an assessment will be completed on each resident utilizing the MDS. The Registered Nurse is responsible for verifying the completion of the assessment. "Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed."	F 641	a. On 3/16/2020, the Nurse Case Manager #1 modified Resident #49□'s Minimum Data Set (MDS) related to anticoagulants. b. On 3/13/2020, the Director of Nursing #1, reviewed the MDS□'s of residents receiving coagulant therapy. There were no other issues identified with the nine(9) resident's MDS. c. On 3/13/2020, the Nurse Case Manager #1 and Assessment Nurse #1 were inserviced by Director of Nursing #1 on MDS accuracy and coding. On 3/18/2020, the Quality Assurance Committee reviewed the policy, "MDS ASSESSMENT", with no recommended changes to the policy. The QA Committee	5/4/20

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

Electronically Signed | 05/07/2020

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F 641	Continued From page 1 A record review of Resident #49's Admission MDS Assessment, with an Assessment Reference Date of 02/07/2020, revealed, Section N410E (Medications Received) was marked to indicate an anticoagulant was given for six (6) during the seven (7) day lookback period for this assessment. Review of Resident #49's "Physician Orders List" of active orders, revealed, orders dated 02/04/2020, for an antiplatelet medication, Clopidogrel 75 milligrams (mg) take one tablet by mouth once a day for diagnosis of Cerebrovascular Accident (CVA), and Aspirin 325 mg tablet take one tablet by mouth once a day for diagnosis of CVA, which was a non-steroidal anti-inflammatory (NSAID) drug. A record review of the Resident #49's Care Plan, revealed a focused problem for potential for injury related to Anticoagulant. On 03/12/2020 at 10:51 AM, during an interview, with Registered Nurse (RN) #1/MDS Coordinator, she revealed, Resident #49's MDS was coded to indicate the resident was receiving anticoagulants. RN #1 revealed that Plavix and Aspirin were not considered to be anticoagulants, but are antiplatelets. RN #1 confirmed the MDS was marked incorrectly. RN #1 revealed the MDS should be coded correctly, because that is how they are aware of how to take care of the resident. RN #1 revealed it was her responsibility to monitor the residents' care plans and MDS assessments.	F 641	recommended additional training of this policy related specifically to MDS accuracy and coding of anticoagulant therapy for Nurse Case Manager #1 and Assessment Nurse #1. d. The Facility Director of Nursing will review MDS prior to transmission for accuracy weekly for 4 weeks beginning 3/19/2020 and then monthly for 2 months. Any areas of concern will be brought by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review. The Director of Nurses will take necessary corrective action plan, as needed, to include additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		5/4/20

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F 645	Continued From page 2 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		

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F 645	Continued From page 3 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) was completed accurately to reflect Resident #40's diagnosis of a Major Mental Illness, for one (1) of 22 residents reviewed. Findings include: A review of the facility's "Pre-Admission	F 645	a. On 3/12/2020, the Social Services Director #1 modified resident #40□s Pre-Admission screening and forwarded to Ascend. b. On 3/13/2020, the Director of Nursing #1, reviewed the Pre-Admission screening forms of residents with a diagnosis of Major Mental Illness. Of the 7 residents reviewed no other issues identified.	

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F 645	Continued From page 4 Screening PAS/PASRR" policy, with a revision date of 10/2018, revealed, anyone applying for admission to a nursing facility must be approved prior to the admission by the Division of Medicaid (DOM) and/or the appropriate Level II authority. When Level I screening on the PAS indicates possible Mental Illness or Intellectual Disability/Developmental Disability and related conditions, the DOM will notify Ascend to review the case. The Level II evaluation must occur prior to admission and whenever the resident has a significant change in status. When Level II evaluation is required the facility must receive an authorization letter approving admission to the nursing facility. The nursing facility must submit the Mississippi Tracking Form to Ascend upon admission of the resident. "The Nurse Case Manager or other facility designee will be responsible for completing the PAS." A review of Resident #40's "PAS Summary and Physician Certification", dated 10/11/2019, revealed the Level II Referral Criteria question, regarding if person has a diagnosis of a major mental illness, was marked "No." Review of the facility's "Face Sheet" for Resident #40, revealed, she was admitted by the facility, on 10/11/2019, with diagnoses which included Spinal Stenosis, Bipolar Disorder, Unspecified Dementia without Behavioral Disturbance and Major Depressive Disorder. A review of the facility ' s "Diagnosis History" for Resident #40, revealed, the onset date for the diagnoses of Bipolar Disorder, Major Depressive Disorder and Unspecified Dementia without Behavioral Disturbance, were as of 10/11/2019, which was also the resident's admission date.	F 645	c. On 3/13/2020, the Social Services Director #1 was inserviced by Director of Nursing #1 on Pre admission screening/PASRR policy. On 3/18/2020, the Quality Assurance Committee reviewed the policy, Pre Admission Screening/PASRR with no recommended changes to the policy or to the training that was conducted for Social Services Director on 3/13/2020. d. The Facility Director of Nursing will review PASRR prior to submission for accuracy weekly for 4 weeks, beginning 3/19/2020, and then monthly for 2 months. Any areas of concern will be brought by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review. The Director of Nurses will take necessary corrective action plan, as needed, to include additional training and/or disciplinary action will be considered as warranted and/or recommended by the QA Committee.	

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F 645	Continued From page 5 Review of Resident #40's Admission Minimum Data Set (MDS) Assessment, with an Assessment (ARD) of 10/17/2019, revealed Section A1500 (PASRR), was checked "No" to indicate the resident had not been evaluated for a Level II screening. Section I (Active Diagnoses) was checked to indicate Resident #40 had diagnoses of Dementia, Depression, and Manic Depression (Bipolar Disease). Resident #40 had a Brief Interview of Mental Status (BIMS) score of 8, which indicated severe cognitive impairment. During an interview, on 03/11/2020 at 11:39 AM, the Director of Nursing (DON) revealed that she thought that a Level II was not done due to resident had a diagnosis of Dementia upon admission. On 03/11/2020 at 12:30 PM, an interview with the DON, revealed, Resident #40's diagnosis of Bipolar Disorder was overlooked, and it should have been added to the PASRR. The DON stated she had spoken with Ascend. She stated that she would review Resident #40 s PASRR, and send it for a Level II evaluation.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		5/4/20

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F 657	Continued From page 6 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to revise care plan related to dialysis treatment for Resident #63, and anticoagulant use for Resident #25, for two (2) of 22 resident care plans reviewed. Findings include: Review of the facility's "Care Plan Process" policy, revised 8/2017, revealed, results of the assessment must accurately reflect the resident's status and needs, to be used to develop, review and revise the resident's comprehensive person-centered plan of care. The comprehensive care plan is an interdisciplinary communication tool. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged,	F 657	a. On 3/13/2020, the Assessment Nurse #1 updated resident #63'□s care plan and Resident #25'□s care plan to accurately reflect dialysis days, dialysis time and location, and dialysis shunt site. b. All residents have the potential to be affected. c. On 3/13/2020, the Nurse Case Manager #1 and Assessment Nurse #1 were inserviced by Director of Nursing #1 on Care plan Process. The in-service included revising care plan as needed for any changes and updates related to specific dialysis information for residents. On 3/18/2020, the Quality Assurance Committee reviewed the policy, Care Plan Process with no recommended changes	

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F 657	Continued From page 7 and must be consistent with each resident's written plan of care. Review of Resident #25's "Care Plan", revealed, a focused problem, with an onset date of 12/30/2019, that addressed the potential for injury related to anticoagulant, with the next review on 03/03/2019. Interventions included to give medications as ordered. A review of Resident #25 ' s "Physician Orders" for March 2020, revealed he was not currently ordered an anticoagulant medication. On 03/12/2020 at 10:53 AM, during an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) Nurse, she stated Resident #25 was on the anticoagulant medication, Lovenox, when he was admitted to the facility, but completed it on 01/16/2020. RN #1 stated she was notified of changes with residents through physician orders. RN #1 stated Resident #25's order for Lovenox would have automatically dropped off without an order, and that it was missed to update the care plan. RN #1 confirmed the care plan was still active, but it had not been revised to indicate Resident # 25 was not currently taking the medication. During an interview, on 03/12/2020 at 11:15 AM, the Director of Nursing (DON) stated the expectation was for the care plan to be updated when changes were noted with residents. The DON stated the MDS Nurse should print the discontinued orders every day, then she would have seen the order drop off from that printout. The DON stated the care plan was important because it was what the staff used to take care of the residents' needs.	F 657	to the policy, and no additional training recommendations were made. d. The Facility Director of Nursing will review residents receiving dialysis treatment and residents receiving anticoagulant treatment□s care plans for accuracy weekly for four (4) weeks, beginning 3/19/2020, and then monthly for two (2) months. Any areas of concern will be brought by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review. The Director of Nurses will take necessary corrective action plan, as needed, to include additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations	

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F 657	Continued From page 8	F 657		

Review of Resident # 25's "Face Sheet" revealed, he was admitted by the facility on 12/30/2019.

Resident #63

Review of Resident #63's Care Plan, revealed a focused problem, with an onset date of 02/27/2018, that addressed the resident's diagnosis of End Stage Renal Disease, with interventions to check shunt site in the right antecubital (ac) for bruit or thrill, check for pain, swelling, redness, heat, drainage (signs of infection) and to avoid blood pressure or labs to be drawn in right arm. The next review date for the care plan was targeted for 04/30/2020.

A review of a focused problem addressed in Resident #63's Care Plan, with an onset date of 03/15/2019, revealed, the resident received dialysis three (3) days a week on Monday, Wednesday, and Friday. The next review date was targeted for 04/30/2020.

Review of Resident #63's "Face Sheet" revealed he was readmitted by the facility, on 05/23/2019, with diagnoses which included End Stage Renal Disease.

Review of Resident #63's "Physician Orders" for March 2020, revealed an order, dated 05/23/2019, for Hemodialysis on Tuesday, Thursday, and Saturday at 1:00 PM.

During an interview and observation, on 03/11/2020 at 2:50 PM, Resident #63 lifted his left arm to reveal the location of his dialysis shunt, and stated it was the arm they used for dialysis.

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F 657	Continued From page 9 An interview, on 03/12/2020 at 10:49, with RN #1/MDS Nurse and the DON, revealed, they both stated that when residents were readmitted from the hospital, if indicated, the Care Plans should be updated to reflect changes in days of dialysis and the location of the shunt site. They also stated that it was important to revise changes in the residents' care plans, as the care plan serves as a guide for nurses in the delivery of resident care. RN #1 stated she had been employed at the facility for four (4) years and that she used the Physician's Orders to update the MDS Assessments and Care Plans. Review of Resident #63's Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 01/29/2020, the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognitive skills. Section O100J (Special Treatments and Programs) revealed the resident was receiving dialysis as a resident of the facility.	F 657		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		5/4/20

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F 812	Continued From page 10 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and policy review the facility failed to maintain the kitchen in a clean and sanitary condition as evidenced by not cleaning the thermometer during tray line temps, and failure to have the dishwasher at recommended water temperatures for two (2) of three (3) kitchen observations. Findings include: A review of the facility's "Guidelines for Using Thermometers" policy, dated 04/2014, revealed: "The facility shall monitor temperatures of hazardous foods to maintain quality and safety of food served. Thermometers are cleaned and sanitized before and after each use to prevent cross contamination." An observation, on 03/10/2020 at 11:00 AM, during tray line temperature checks, Dietary Staff (DS) #2 checked food items, and did not clean the thermometer between checking each item. DS #2 checked the roast beef, chopped roast beef, pureed roast beef, mixed vegetables, pureed vegetables, rice, pureed rice, chopped pork meat and beans. Four (4) of the food items (chopped roast beef, pureed vegetables, pureed rice and pork meat) were below the required holding temperature of 135 degrees. DS #2 only cleaned the thermometer when she re-checked	F 812	a. On 3/10/2020, the food was removed from the tray line and second batches of the meal for serving residents and employees was placed on the serving line. Proper food temperature check procedures were followed. On 3/11/2020, facility residents were served on Styrofoam plates and utensils. Facility Maintenance Director and plumbing contractor made a temporary repair on 3/11/2020 and ensured the facility dish machine was functioning appropriately. On 3/17/20, the Plumbing Contractor replaced a Hi-temp switch and thermostat. b. All residents have the potential to be affected by this deficient practice. c. On 3/13/2020, the Dietary Staff were inserviced by Dietary Manager #2 on guidelines of using thermometers and machine ware washing procedures. On 3/18/2020, the Quality Assurance Committee reviewed the policy, Guidelines for using thermometers and Machine Ware Washing with no recommended changes to the policy were made and no recommendation of additional training to the training already conducted.	

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F 812	Continued From page 11 the pork meat and the chopped roast beef. During an interview, on 03/12/2020 at 9:28 AM, with the Dietary Manager (DM), she stated not cleaning the thermometer between temperature checks of food items was an issue. The DM stated the risk was the possible spread of contamination of the food. The DM revealed DS#2 had been working at the facility for over 20 years. The DM stated the last dietary training was done last year and included competencies. Review of the facility's "Inservice Training", dated 11/21/2019, revealed, DS #2 was in attendance for the training for Dietary Staff Employees and had taken the "Competency Test", which covered temperature checks. Dishwasher Review of facility's "Machine Warewashing" policy, dated 05/2018, revealed, the wash and rinse temperatures of ware washing machines that use chemical sanitizing should meet the temperature posted on the machine. On 03/11/2020 at 8:51 AM, an observation of the dishwasher cycle with DS #3, revealed, the dishwasher had a water temperature of 115 degrees for two (2) wash cycles. On 03/11/2020 at 8:55 AM, during an interview with DS #3, she revealed that the temperature should be in the "green" on the dishwasher thermometer. The temperature hand stayed in the "blue" portion on the thermometer. DS #3 stated all the dishes had been washed from breakfast. DS #3 stated she had been working at the facility for about two (2) weeks, and that she	F 812	d. The Facility Administrator will monitor Food temperature procedures and Dishwasher temperatures daily for fourteen (14) days beginning 3/11/2020, then weekly for four (4) weeks and then monthly for two (2) months. Any areas of concern will be brought by the Administrator to the quarterly Quality Assessment and Improvement Committee for review. The Administrator will take necessary corrective action plan, as needed, to include additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12 was still in training. Review of DS #3's "Food Service and Nutrition Department Employee Orientation Checklist" revealed proper operating procedures for equipment, and machine and manual ware washing was covered on 02/14/2020. On 03/11/2020 at 9:13 AM, during an interview with the DM, she stated the temperature range was about 125 degrees and pointed to the manufacturer's sticker on the dishwasher, which had the temperature listed at 125 degrees. The DM stated unclean dishes were a risk for the spread of infection. She stated the facility's policy was to use paper plates, until the dishwasher was working. The DM stated all the dishes would have to be cleaned again, when the dishwasher was working. She stated that Maintenance was aware of the issue with the dishwasher. Review of the "Dishmachine Temperature/Chemical Log" for March 2020, revealed, temperature checks were below 125 degrees for 15 out of 34 temperature checks performed, from 03/01/2020 through 03/11/2020. On 03/11/2020 at 9:19 AM, during an interview with the Maintenance Director, he stated that he was aware of the issue and had called a plumber last week, but they couldn't be here until this week. The Maintenance Director did not indicate a specific date that the plumber was notified. The Maintenance Director stated he called (Name of Dishwasher Manufacturer), and they told him that the dishwasher still cleans at 110 degrees. The Maintenance Director confirmed that the water temperature was too low. The Maintenance Director stated the plumber would have to make	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

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F 812	Continued From page 13 a new line, with a dedicated line from the hot water heater to the dishwasher. The Maintenance Director stated that he didn't know when it happened, but he realized when they used the sprayer beside the dishwasher, the temperature would not get high enough. Review of the "Maintenance Jot Book" revealed, the DM notified Maintenance of the problem regarding low water temperature on the dishwasher, on 03/03/2020. The Maintenance Director initialed that the work was completed on 03/04/2020. On 3/12/2020 at 9:50 AM, during an interview with the Maintenance Director, he confirmed that he signed the "Maintenance Jot Book" on 03/04/2020. The Maintenance Director stated his initials were to acknowledge his awareness of the issue, and that he was working on it. The Maintenance Director revealed the work on the dishwasher was not completed that day (03/04/2020).	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	**587 JOHN R JUNKIN DRIVE** **NATCHEZ, MS 39120**

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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 | 05/07/2020

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
	255169	A. BUILDING _____ B. WING _____	03/11/2020

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E 000	Initial Comments ********** Survey conducted on 03/11/20 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 | 05/07/2020

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.