

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER SINGING RIVER HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 MAIN STREET MOSS POINT, MS 39563		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A COVID-19 Focus Infection Control Survey along with a complaint investigation (CI MS #16590, CI MS #16643, CI MS #16777) was conducted by the State Agency (SA) on 10/12/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. At the time of the survey, the facility had a census of 107 and held a license for 160 beds. CI MS #16590 The result of the investigation was unsubstantiated with no deficiencies cited for Resident Rights related to Resident Not Treated With Dignity. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #16643 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care, Misappropriation of Property related to Resident Personal Items. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. CI MS #16777 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Resident Safety. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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