STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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 re-certification survey at the facility from 8/12/19 to 8/15/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficient practice at F679. The census at the time of the survey was 96, and the facility was licensed for 120 beds.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility policy review, and record review the facility failed to ensure a resident who desired to attend morning activities was up and able to do so. Resident #50; one (1) of 18 residents interviewed for activities. Findings include: Review of the facility's policy titled, "Activities", with a revision date 11/28/17, revealed: 1. Activity Program Development: Activities should be	F 679	Resident #50 was interviewed by the Activities Director on 8/14/2019 about her desire to attend morning activities. Restorative staff will ensure Resident #50 will be up daily to participate in morning activities. Attendance and participation will be documented by the Activities Director. The facility has determined that all residents have the potential to be affected.	8/29/19

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

Electronically Signed — 08/28/2019

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
	255268	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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 679	Continued From page 1 designed to provide meaningful activity to each resident, consistent with his or her background and interest. In planning activities, the staff should consider: Plans to encourage residents to attend, or to promote the activity, assistance for residents to get to activities. On 08/12/19 at 11:15 AM an interview with Resident #50 revealed she enjoyed the activities at the facility and would like to attend the morning activities but is not up in time. Resident #50 stated she had been up about 15 minutes and that she is usually up by 11:00 AM but activities are usually over by then. Observation throughout the survey, on 8/13/19 at 10:00 AM and 11:15 AM revealed Resident #50 in her room and receiving care by staff. On 08/13/19 at 11:15 AM an interview with Resident #50 revealed she was up in her room and sitting in her wheelchair. Resident #50 stated she had been up about 15 minutes. Review of the Activities Roster revealed Resident #50 attended six (6) morning activities during the month of May, five (5) morning activities in June, three (3) morning activities in July, and one (1) morning activity in August. A review of Resident #50's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD), 7/19/19, Section F - Preferences for Customary Routine and Activities revealed, it is very important to resident that she choose to do favorite activities, go outside when good weather, and participate in religious practices. Section C of the MDS revealed Resident #50 had a Brief Interview for Mental	F 679	The Director of Nursing conducted an in-service with Restorative Nurse, Restorative Nurse Assistants, and Activity Directors on 8/14/2019 on the importance of ensuring Resident #50 is up daily for morning activities. Activity staff will document attendance and participation to ensure compliance. Administrator had observed resident participating in morning activities and interviewed resident on 8/29/2019 to confirm she is attend morning activities as she desires. The Director of Nursing and Quality Assurance Nurse will review Resident #50 attendance and participation records to ensure compliance. Findings will be brought to Quality Assurance monthly meeting until such time consistent satisfaction is reported by the Director of Nursing and Administrator. The QA committee will make recommendations or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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 679	Continued From page 2 Status score of 15, which indicated Resident #50 was alert and oriented. On 08/13/19 at 2:10 PM an interview revealed Certified Nursing Assistant (CNA) #1 stated Resident #50 likes to get up about 9-9:30 so she can go to activities and she tries to have her up by then. On 08/13/19 at 2:26 PM an interview revealed CNA #2 stated she has 50 occasionally and she tries to have up by 9:30. CNA #2 stated sometimes it is around 10:00. CNA #2 stated Resident #50 attends some morning activities especially church, singing activities, and bingo. On 08/13/19 a 2:46 PM, an interview revealed the Activities Coordinator (AC) stated Resident #50 does enjoy activities and participates well when she is up. The AC stated Resident #50 is generally up between 10:30 and 10:40 AM. The AC stated at times she reminds staff that Resident #50 doesn't want to miss activities and encourages them to ensure she is up. The AC stated she felt that Resident #50 would attend more activities if she were up in time to go. On 08/14/19 at 8:55 AM, an interview revealed CNA #3 stated Resident #50 likes to be up by 10:00 to go to activities. CNA #3 stated she usually has her up by 10:30 to 11:00. CNA #3 stated Resident #50 has told her in the past that she wants to get up for activities and she has reported that to her CNAs, but she doesn't recall notifying a nurse. CNA #3 stated if they have enough staff its possible to have her up by 9:30, but if they are short, it is later. CNA #3 stated she works Restorative, but she tries to come to the floor to assist in getting Resident #50 up.	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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 679	Continued From page 3 On 08/14/19 at 9:43 AM, an interview revealed the Director of Nursing (DON) stated she was not aware that Resident #50 had requested to be up for morning activities. The DON stated plans will be made to ensure Resident #50 is up in time for activities.	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. BUILDING **01 - BUILDING 0101** B. WING _____	**08/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	**118 SOUTH GLENFIELD ROAD** **NEW ALBANY, MS 38652**

(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
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 | 08/27/2019

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
	255268	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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
E 000	Initial Comments ********** Survey conducted on 08/15/19 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 | 08/27/2019

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.