STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. BUILDING _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification and complaint, CI MS #16660, survey at the facility from 2/25/2020 to 2/27/2020. The complaint was related to inappropriate discharge. During the survey, the SA did not substantiate the complaint and no deficiencies were cited related to the complaint. The SA did determine the facility was not in compliance with the requirements for participation in Medicare and Medicaid, and cited F656, F695 and F880. The census at the time of the survey was 111 and the facility was licensed for 120 beds.	F 000		
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	F 656		3/27/20

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

Electronically Signed | 03/31/2020

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.

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F 656	Continued From page 1 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 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, staff interview, resident interview and facility policy review, the facility failed to develop a Comprehensive Care Plan for Resident #22's Oxygen (O2) use, to include approaches for the storage of Resident #36's O2 cannula and tubing when not in use and implement Resident #3's need for heel boots and/or pillows to prevent new pressure areas. This concern was identified for three (3) of 24 care plans reviewed. Findings include: Review of the facility's "Intermediate Care Plan Policy", not dated, revealed, "It is the policy of this facility that the intermediate care plans will be done as follows: As needed in an acute situation. Completed by the floor nurse at the time the	F 656	Statements contained herein are intended for Purposes of compliance with Federal and State laws regarding responses to Statement Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of Compliance with participation requirements Medicare and Medicaid. F656 (1) Resident # 22□s care plan was updated on 2/27/2020 to include use of oxygen by the Director of Nursing. Resident # 36 care plan was updated on 2/28/2020 to include that oxygen tubing should be stored in a bag when not in use	

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F 656	Continued From page 2 situation occurs. Resolved when the situation is stable. Added to the long term plan by the MDS (Minimum Data Set) Nurse if the situation continues when the quarterly review is due. Review of the facility's "Oxygen Policy", dated 3/1/2004, revealed oxygen use should be care planned and store the O2 cannula in a zip lock bag when not in use. Resident #22 Review of Resident #22's care plans in the paper chart and electronic medical record revealed there was no care plan for oxygen developed. An observation, on 2/25/2020 at 11:00 AM, revealed Resident #22's O2 cannula and tubing was draped across the O2 concentrator in her room. Resident #22 was not in the room at this time. Review of a Physician's Telephone Order, dated 2/23/2020, revealed an order for continuous Oxygen (O2) at two (2) liters (L) biprong nasal cannula (BNC) per concentrator or tank. Review of a Physician's Telephone Order, dated 2/25/2020, revealed an order to change continuous O2 to as needed (PRN) for O2 saturation (Sat) less than (<) 93%. An interview, on 2/27/2020 at 11:00 AM, with Registered Nurse (RN) #1, revealed Resident #22 had not used the O2 recently. An interview with Licensed Practical Nurse (LPN) #1/Minimum Data Set (MDS) Coordinator, on 2/27/2020, at 10:05 AM, revealed LPN#1	F 656	by the Director of Nursing. For Resident #3 the Director of Nursing applied heel well boots 2/28/2020 (2) The facility has determined all residents who use oxygen and heel well boots have the potential to be affected by failure to develop and implement a Comprehensive Care Plan. (3) On 3/2/2020 Registered Nurses, Licensed Practical Nurses, and Respiratory Therapist, were in serviced by the Staff Education Nurse on the development of the resident□s care plan to include that the use of oxygen and storage of oxygen tubing when oxygen is not in use must be addressed on the care plan. On 3/3/2020 Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants were in serviced by the Staff Education Nurse to include that interventions, such as heel well boots, listed on the resident□s plan of care are to be implemented. On 3/2/2020 the Minimum Data Set Nurses initiated a 100% audit of care plans for all residents who received oxygen to ensure the comprehensive care plan included the use of oxygen. On 3/2/2020 Quality Assurance Nurse #2 initiated a 100% audit to ensure all resident who were care planned to have heel well boots were wearing heel well boots as indicated on the care plan.	

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F 656	Continued From page 3 confirmed a care plan for Resident #22's oxygen was not developed. LPN #1 stated MDS does the majority of care plans with the assessments and updates the care plans when the assessments are due. LPN#1 stated, "I could not find one in here. It should have been developed when the order was taken. The purpose of a care plan is to know how to take care of our patients, to know what we need to do to take care of their needs and what their preferences are." On 2/27/2020, at 10:15 AM, during an interview with the Respiratory Therapist (RT), revealed she had taken the order for oxygen on 2/23/2020, and had checked and initialed the box "Pt. Care Plan" on the Physician's Telephone Orders. The RT stated "I don't remember writing the care plan. We're supposed to update it in the hard chart and the computer when a new order is given. The purpose of a care plan is so we know the plan of care for that resident and follow the plan of care to make sure we are doing everything we can to take care of our residents". Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 12/12/2019, with diagnoses which included Acute Bronchitis, Heart Failure, Mild Cognitive Impairment and Unspecified Escherichia Coli as the Cause of Diseases Classified Elsewhere. Resident #36 Review of Resident #36's Comprehensive Care Plan revealed the Problem/Need, dated 3/29/2018, for Chronic Obstructive Pulmonary Disease (COPD), wheezing and cough. The approaches included the use of O2 as needed (PRN) at 2 LPM (Liters per minute) per tank or	F 656	(4) Quality Assurance Nurse #1 began a weekly audit on 3/13/2020 that will extend for four weeks to include checking oxygen orders to ensure that the use of oxygen and storage of oxygen tubing is addressed on the care plan. Quality Assurance Nurse #2 began a daily audit, Monday through Friday on 3/2/2020 that will extend one week; then weekly for four weeks to ensure that residents care planned to use heel well boots have heel well boots in use. All discrepancies will be brought to the Director of Nursing for further review and corrective action. The Quality Assurance Nurses will bring all discrepancies to Quality Assurance committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 3/16/2020 and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

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F 656	Continued From page 4 concentrator and monitor effectiveness. The care plan did not address the storage of the O2 cannula and tubing when not in use. On 2/25/2020 at 8:35 AM, an observation during the initial tour, revealed Resident #36's nasal cannula was draped over the O2 concentrator and there was no bag to put it in. An interview at this time with Resident #36 revealed she stated, "I ain't seen a bag over there for a good minute." On 2/27/2020 at 10:35 AM, during an interview with the Care Plan Nurse, she stated MDS does a majority of the care plan revision when they are reviewed for the MDS process. The Care Plan Nurse said the resident's care plan was just reviewed due to having an MDS, and we should have caught the fact she had no change tubing orders during the care plan review and we didn't. Resident #3 Review of Resident #3's Comprehensive Care Plan, dated 11/11/2014, revealed the Problem/Need for Pressure Ulcer risk related to (r/t) limited mobility, impaired cognition and incontinence. The Goal & Target Date: Will develop no new pressure areas thru (through) 5/19/2020. The approaches included: Heel Well boots to BLE (Bilateral Lower Extremities) at all times. If unable to keep heel well boots in place, position pillow in between resident's feet to provide pressure relief, dated 1/13/2019. Further review of the care plan revealed the Problem/Need, dated 10/15/2015, for Smart Chart - Schedule with the included approaches: Pressure relief boot in while in bed. On 2/25/2020 at 8:40 AM, an observation during	F 656		

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F 656	Continued From page 5	F 656		

the initial tour revealed Resident #3 was lying in his bed without his heel boots on. The boots were sitting in his Geri-chair in the corner.

On 02/25/20 at 2:49 PM, an observation revealed Resident #3 was lying in the bed with his feet resting on the footboard. Resident #3 was laying diagonally in bed, with his head at one corner at the head of the bed and the his feet in the corner on the opposite side at the foot of the bed (catty-cornered) with his pillow in the floor. His heel boots were sitting on his Geri-chair in the corner.

On, 2/26/2020 at 8:05 AM, Resident #3 was observed lying in the bed without his heel boots on and there was no pillow between his feet as care planned.

On, 2/26/2020 at 2:20 PM, Resident #3 was lying in the bed without his heels boots on and there was no pillow between his feet for positioning.

On, 2/26/2020 at 2:30 PM, during an interview with the Director of Nursing (DON), the DON stated, "He should either have the heel boots on or the pillow between his feet. He is resistive to care sometimes".

On 2/27/2020 at 10:35 AM, an interview revealed LPN #1/Care Plan Nurse, stated, "MDS does a majority of the care plan revision when they are reviewed for the MDS process; however, the nurses and department heads are to update the care plan with the new orders and behavior. We just had a care plan review for him.

Review of the Face Sheet revealed Resident #3 was admitted by the facility, on 8/14/2014, with

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F 656	Continued From page 6 diagnoses which included Adult Failure to Thrive, Unspecified Dementia without behavioral disturbance, Anemia, Functional Quadriplegia, and Blindness, one eye, low vision other eye.	F 656		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 store the resident's oxygen cannula and tubing in a manner to prevent the possibility for infection or cross contamination for two (2) of three (3) residents reviewed for oxygen therapy, Resident #22 and #36. Findings include: Review of the facility's "Oxygen Policy", dated March 1, 2004, revealed, "It is the policy of this facility that oxygen will be utilized included: With specific physician's order. Date the tubing and the humidifier. Document the tubing change on the MAR (Medication Administration Record) (Tubing is to be changed weekly). Care plan the oxygen usage. Store the Oxygen cannulas in a ziplock bag when not in use.	F 695	F695 (1) Resident # 22□s oxygen tubing was replaced on 2/25/2020. Oxygen tubing was stored in a bag and dated for 02/25/2020 by Licensed Practical Nurse #2. Resident #36□s oxygen tubing was replaced on 2/25/2020. Oxygen tubing was stored in a bag and dated for 02/25/2020 by Quality Assurance Nurse #1. The Respiratory Therapist received a one on one counseling to include that oxygen and cannulas are to be stored in bags and never back dated. On 2/26/2020 Resident #36□s physician□s orders were updated to include an order to change oxygen tubing	3/27/20

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F 695	Continued From page 7 Resident #22 On 2/25/2020 at 11:00 AM, during the initial tour of the facility, an observation revealed Resident #22's oxygen (O2) tubing was draped across the oxygen concentrator in the resident's room. There was no date on the tubing or humidifier bottle. Licensed Practical Nurse (LPN) #2 was called into the room and confirmed there was no date on the tubing and that it was not stored properly. LPN#2 reported the tubing should be labeled with the date it was placed and in a bag so nothing is dropping on the floor. It's normally changed every Saturday. LPN #2 stated, "We don't want to cross contaminate anything, get germs or anything like that". Review of a Physician's Telephone Order, dated 2/23/2020, revealed an order for continuous Oxygen (O2) at two (2) liters (L) biprong nasal cannula (BNC) per concentrator or tank. Review of a Physician's Telephone Order, dated 2/25/2020, revealed an order to change continuous O2 to as needed (PRN) for O2 saturation (Sat) less than (<) 93%. Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 12/12/2019, with diagnoses which included Acute Bronchitis, Heart Failure, Mild Cognitive Impairment and Unspecified Escherichia Coli as the Cause of Diseases Classified Elsewhere. Resident #36 On 02/25/20 at 8:35 AM, an observation, during the initial tour, revealed Resident #36's O2 nasal cannula was draped over the O2 concentrator	F 695	weekly on Sunday. On 2/27/2020 at 10am Resident #22 and Resident #36 were assessed by the Assistant Director of Nursing and found not to have any signs or symptoms of infection at that time. (2) The facility has determined that all residents who use oxygen have the potential to be negatively affected by the failure to store oxygen cannula and tubing in a manner to prevent the possibility for infection or cross contamination. (3) On 3/3/2020 an in-service was initiated by the Staff Education Nurse for Registered Nurses, Licensed Practical Nurses, Respiratory Therapist to include that oxygen was to be stored in a bag when not in use, the oxygen is to be changed out weekly and the tubing/bag is to be dated on the day that it is changed out. On 3/25/2020 the night shift Respiratory Therapist changed out all oxygen tubing and bags and dated them for the day they were changed out. (4) The Assistant Director of Nursing and the Order Entry Nurse initiated a daily audit, Monday through Friday, to ensure that oxygen orders included an order to change tubing weekly on Sundays. Quality Assurance Nurse #1 began a daily audit on 3/2/2020, Monday through Friday, to extend for one week on to ensure that	

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F 695	Continued From page 8 and there was no bag to store it in. Resident #36 was sitting at her bedside, and an interview with her at this time revealed she stated, "I ain't seen a bag over there for a good minute." An observation, on 2/25/2020 at 11:30 AM, revealed Resident #36's nasal cannula was now in a ziplock bag, dated 2/22/2020. Review of Resident #22's February 2020 Physician's Orders revealed an order, dated 9/30/2019, for O2 PRN at 2 LPM (Liters per minute) per tank or concentrator r/t (related to) SOB and COPD (Shortness of Breath and Chronic Obstructive Pulmonary Disease. On, 2/25/2020 at 11:40 AM, an interview with the Respiratory Therapist (RT) regarding Resident #36's O2 cannula and tubing observed in a ziplock bag now, revealed she stated, "I saw that her oxygen cannula was draped over her concentrator in her room, and they are supposed to all be bagged. So, I went to central supply and got a bag and attached it to the concentrator for her." The RT stated, "I guess I just dated it for when I knew it should have been changed. They change them on the night shift on Sunday nights." An interview, on 2/26/2020 at 3:30 PM, revealed the Director of Nursing (DON), stated she "had looked all through her chart, and there is no order for them to sign when they change out the oxygen tubing, and it is not on the care plan. So I guess they just know to do it". Review of Resident #36's February 2020 Medication Administration Record (MAR) revealed there were no orders or documentation for changing/dating the O2 cannula and tubing.	F 695	oxygen is changed, labeled and stored correctly. Then Quality Assurance nurse will continue audit weekly. The Medical Records Nurse will audit oxygen orders monthly to ensure that oxygen orders included an order to change tubing weekly on Sundays. All discrepancies will be brought to the Director of Nursing for further review and corrective action. The Quality Assurance Nurses will bring all discrepancies to Quality Assurance committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 3/16/2020 and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

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F 695	Continued From page 9 Review of the Face Sheet revealed Resident #36 was admitted by the facility, on 3/29/2020, with diagnoses which included Chronic Obstructive Pulmonary Disease, Secondary Malignant Neoplasm of Unspecified Lung, Heart Failure, Cough, and Wheezing.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		3/27/20

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F 880	Continued From page 10 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to prevent the	F 880	F880	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

(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 880	Continued From page 11 potential spread of infection during the medication administration observations for one (1) of six (6) residents observed. Findings include: Review of the facility's "Employee Hand Hygiene Policy", not dated, revealed hand hygiene is required before and after direct resident contact and after handling soiled equipment or utensils. Review of the facility's "Infection Prevention and Control Program" policy, dated 11/13/2017 revealed hand hygiene protocol includes all staff shall wash their hands when after handling contaminated objects. On, 2/26/2020 at 9:10 AM, an observation of Licensed Practical Nurse (LPN) #3 administering medications to Resident #29 revealed all medications were given except the Allegra. After administering the medications, LPN #3 went to the West Medication Storage Room, opening the door, touching the door knob, pulling open a drawer and going through all of the medication cards looking for the Allegra. After LPN #3 did not find the Allegra in the West Medication Storage Room, she went to the East Medication Storage Room and opened the door, touching the door knob, opening the drawer and going through the cards of medications and again not finding the Allegra. While LPN #3 was walking back to the West Hall another nurse alerted LPN #3 that she found the Allegra. LPN #3 then returned to the medication cart and placed an Allegra pill in a medication cup, and returned to Resident #29's room and administered the medication. LPN #3 did not use the anti-bacterial gel or wash her hands after looking for the Allegra in the storage	F 880	(1) For Resident #29, Licensed Practical Nurse #3 received a one on one counseling to address failure to clean her hands after going to the medication rooms and before administering the Allegra to Resident #29. On 2/27/2020 at 9am Resident #29 was assessed by the Assistant Director of Nursing and found to have no negative outcomes from Licensed Practical Nurse #3s failure to wash her hands after going to the Medication Storage room. (2) The facility has determined that all residents who receive medication have the potential to be affected by failure to prevent the potential spread of infection during medication administration. (3) On 3/2/2020 an in-service, covering the Employee Hand Hygiene Policy, was initiated by the Staff Education Nurse for Registered Nurses, Licensed Practical Nurses, Respiratory Therapist to include that hand hygiene is required before and after direct resident contact and after handling soiled equipment or utensils. In-service training includes observation of Licensed Practical Nurses and Respiratory Therapist performing hand hygiene procedures during medication administration. Findings are reviewed with all personnel. Corrective action is provided as needed. (4) The Infection Preventionist will perform weekly observation of Licensed Practical Nurses and Respiratory Therapist performing hand hygiene procedures	

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	255296	A. BUILDING _____ B. WING _____	02/27/2020

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DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

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F 880	Continued From page 12 rooms, after touching door knobs, drawer pulls and many medication cards before administering the medication. On, 2/26/2020 at 9:20 AM, an interview with LPN #3 confirmed she did not wash her hands or use the anti-bacterial gel after going to the East and West Medication Storage Rooms and before administering the Allegra to Resident #29. LPN #3 confirmed her hands would be contaminated and could cause the spread of infection. On, 02/26/2020 at 10:15 AM, an interview with the Assistant Director of Nursing (ADON) confirmed LPN #3 should have used the hand gel or washed her hands after going to the West and East Medication Rooms to look for a medication. The ADON revealed LPN #3 contaminated her hands touching the door knobs and drawer pulls.	F 880	during medication administration for four weeks; then monthly. All discrepancies will be brought to the Director of Nursing for further review and corrective action. The Infection Preventionist will bring all discrepancies to Quality Assurance committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 3/16/2020 and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	**7805 SOUTHCREST PARKWAY** **SOUTHAVEN, MS 38671**

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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 | 03/31/2020

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
	255296	A. BUILDING _____ B. WING _____	02/28/2020

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E 000	Initial Comments ********** Survey conducted on 02/28/20 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 | 03/31/2020

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.