STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 along with complaints MS #20619 and MS #20783 from March 27 to March 29, 2023. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies F561 and F812. Anonymous reported complaint MS #20783 for accidents, visitation, dietary and Activities of Daily Living (ADL's) was investigated and and no deficiency was cited. Complaint MS #20619 was investigated for staffing and medications and no deficiencies were cited related to this complaint. Census at the time of survey was 46 and the facility has beds for 60 residents.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		5/18/23

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

Electronically Signed | 04/18/2023

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
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review the facility failed to honor food preferences for one (1) of fifteen residents reviewed for food preferences. Resident #6 Findings include: Review of the facility's, "Resident Food Preferences" policy with no revision date, revealed, Food likes and dislikes, 1. Upon the resident's admission, or within twenty-four hours after his/her admission, the Dietitian or nursing staff will identify a resident's food preferences. When possible, this will be done by direct interview with the resident. Review of the facility's, "Resident Rights" policy with no revision date, revealed, Residents are entitled to exercise their rights and privileges to the fullest extent possible. An interview on 03/27/23 at 03:15 PM, Resident #6 revealed "I eat breakfast in my room since I have a colostomy and it's just easier in the morning to stay in here. I have told them that I	F 561	1. Dietary Manager and Director of Nursing interviewed Resident # 6 and all other residents regarding dietary likes/dislikes to determine resident preferences. Spread sheet created to record findings and tray cards were updated accordingly. Interviews completed 4/12/23. 2. On 4/12/23 it was determined that all residents, with the exception of two NPO residents, could be affected by the deficient practice. Director of Nursing and Dietary Manager conducted audits on 4/12/23 to ensure all tray cards matched resident preferences. 3. All staff in-service conducted on Residents Rights with a special focus on food preferences. In-servicing began 4/12/23 and completed 4/17/23. Dietary Manager and Director of Nursing conducted audit of Resident # 6 and all other resident tray cards against Physician prescribed diets for accuracy. Audit completed 4/12/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 561	Continued From page 2 don't want sausage and cereal; I do like grits and oatmeal that's easier to chew. I don't have a lower bottom denture, but I'm supposed to go and get it tomorrow. They continue to send me sausage and cereal despite me telling them not to and it being on my paper not to send. A lot of times I just soak the cereal in the milk until it gets to where I can chew it." An interview on 03/28/23 at 10:25 AM, Certified Nurse Aide (CNA) #1 revealed the resident is out this morning to get her bottom dentures. She revealed if a resident has something that they aren't supposed to have it is on their meal ticket. She revealed the resident ate 75% of her breakfast. She couldn't remember what all it was. An interview on 03/28/23 at 02:11 PM, the Dietary Manager revealed that the resident does not like sausage and will usually get bacon instead. She revealed a while back Resident #6 voiced about not liking sausage and cereal and did like oatmeal and grits. She revealed she immediately put it on her meal ticket and now she is not served those items. She revealed, part of the issue is because of not having a bottom denture but she is gone today to get them. An observation and interview on 03/29/23 at 8:35 AM, Resident #6 sitting in her room, a pre-packaged fruit loops cereal container noted with milk in it on the overbed table. She revealed they brought in grits, sausage, egg and cheese biscuit. I ate the egg and grits and sent the rest back, they know I don't like sausage and this hard cereal but they keep sending. She revealed I just put the milk in the cereal to get it soft so I can eat it.	F 561	4. Registered Dietician to follow up on food preferences by conducting at least 3 resident interviews regarding likes/dislikes and food preferences. Interviews to begin on 5/4/23 and will be completed by 5/15/23. Tool implemented for Dietary Manager or Tray Aide to monitor no less than 5 trays per meals to ensure food served coincides with residents preference daily for one week, then weekly for three months. In-service for monitoring tool conducted 4/18/23 and tool implemented on 4/19/23 with breakfast meal. Emergency QA held on 4/18/23 and food preferences added to ongoing Quality Assurance Committee monitoring. Follow up Quality Assurance meeting to be held 5/15/23 and will be quarterly thereafter. 5. The corrective action will be completed by 5/18/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 561	Continued From page 3 An interview on 03/29/23 at 8:45 AM, the State Agent (SA) inquired of what Resident #6 was sent out for breakfast. Dietary Worker #1 revealed she got grits, sausage, egg and cheese biscuit and cereal, everybody got that. She confirmed on the breakfast meal ticket it states, no sausage, no cereal only oatmeal and grits and the sausage and cereal should not have been sent. An interview on 03/29/23 08:55 AM, with the DM and Dietary Worker #1, the DM revealed that Resident #6 is not to have sausage and cereal for her breakfast as is written on her meal ticket. She confirmed that they had failed to follow Resident #6's food choices by sending her foods that she had requested not to have and that the workers probably just got in a hurry. Review of the breakfast meal ticket for Resident #6 dated 03/29/23 revealed under Notes: No sausage, no cereal only oatmeal and grits. Review of Resident #6's Face Sheet revealed she was admitted to the facility on 11/18/22 with diagnoses that included Nontraumatic intracerebral hemorrhage in cerebellum, and Malignant neoplasm of colon. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/22/2023, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident had full cognitive ability.	F 561		
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 -	F 812		5/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 4 §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. (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 and facility policy review, the facility failed to clean the ice machine that served the residents and staff as evidenced by five (5) spots of a black substance on the ice inside the ice machine for one (1) of three (3) survey days. Findings include: Record review of the facility policy titled, "Ice Machines and Ice Storage Chests" with a revision date of April 2012 revealed under "Policy Statement...Ice-making machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice". Record review revealed a typed statement from the Administrator that the facility has no written policy on the cleaning of the ice machines.	F 812	1. New ice machine installed in the kitchen on 3/30/2023 and functioning properly. Ice machine at Nurses Station put out of service on 3/29/23 and ice was purchased and stored in med room freezer. On 4/11/23, ice machine at Nurses Station was repaired, cleaned and sanitized and is functioning properly. 2. On 3/29/23 it was determined that anyone who gets ice from the ice machine could be affected by the deficient practice, therefore ice machine was put out of service on 3/29/23. 3. All staff in-service conducted regarding ice machine malfunction and reporting to maintenance and administration. In-services started 4/13/23 and completed 4/17/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 5 An interview and observation on 3/28/23 at 4:00 PM, with the Dietary Manager revealed that the ice machine in the kitchen had quit working about two weeks ago. She revealed a new ice machine had been purchased and received but not installed yet. She revealed that the only ice machine functioning in the facility was behind the nurse's desk. An observation on 03/29/23 at 8:50 AM, revealed approximately five (5) spots of a black substance stuck to the ice in the only ice machine (behind the nurses desk) functioning in the facility. An observation and interview on 3/29/23 at 8:52 AM, with the Director of Nurses (DON) confirmed there were 5 spots of a black substance stuck to the ice in the ice machine behind the nurses desk. She revealed that the ice machine should be cleaned according to the manufacturer's directions. She revealed that the 5 spots of black substance were more than likely mold and could cause gastrointestinal(GI) upset such as nausea and diarrhea. She confirmed this ice machine was the only one functioning in the facility and provides all ice to all residents and staff for both meals and hydration carts. She revealed she is not sure how often the ice machine gets cleaned but it was the responsibility of maintenance. An interview on 3/29/23 at 9:45 AM, with the Maintenance Director confirmed maintenance is responsible for cleaning the ice machines once per month. He revealed that when he cleans the ice machine, he empties all of the ice out of the machine, gets a rag and some sanitizer and cleans the mold off. He revealed that sometimes there is black substance on the ice and they	F 812	4. Maintenance Supervisor or Charge Nurse will monitor cleanliness of ice machines daily in addition to regularly scheduled monthly cleaning to ensure food service safety for all residents. If contamination noted, ice machine to be put out of service. This monitoring will be done daily beginning 4/19/23 until follow up Quality Assurance meeting completed on 5/15/23, then weekly for 3 months. Tool implemented for Maintenance Supervisor to perform weekly ice machine inspections for 3 months, then to continue monthly. Monitoring began 4/10/23. Emergency Quality Assurance meeting held 4/18/23 and maintenance monitoring of ice machines added to on-going Quality Assurance Committee monitoring. Follow up QA to be held 5/15/23 and will be quarterly thereafter. 5. The corrective action will be completed on 5/18/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255334	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 6 have to remove all of the ice, clean and start over. An interview on 3/29/23 at 11:22 AM, with Infection Control Nurse and Licensed Practical Nurse (LPN) #1 revealed the Infection Control Nurse confirmed that the black substance on the ice in the ice machine was probably mold which could lead to some health issues, but she was not sure specifically what health issues without doing some research. LPN #1 confirmed that drinking ice with the black substance on it, could lead to GI upset. They confirmed that the ice machine behind the nurse's desk provided ice to all residents and staff. An interview on 3/29/23 at 12:05 PM, with the Administrator confirmed that the ice machine is supposed to be cleaned monthly by the maintenance department, but the facility does not have a written policy stating that. She revealed that it is an understood policy for the maintenance department to clean the ice machine monthly.	F 812		