STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	**1120 RITCHIE AVE** **CLARKSDALE, MS 38614**

(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 must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to provide the documentation for combustible decorations in accordance with NFPA 101 section 19.7.5.6.(1) standard for combustible decorations. The deficient practice affected all smoke compartments and residents in facility on the day of survey. Findings Include:	K 753	K-753 Combustible Decorations 1. Maintenance completed taking down all window curtains on 4/28/23. 2. All smoke compartments and residents have the potential to be affected by this deficient practice.	5/5/23

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

Electronically Signed | 04/24/2023

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.

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	255267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2023**

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K 753	Continued From page 1 On 4/4/23 at 11:30 AM, observation revealed the window curtains in all resident rooms did not have flame retardant tags. Interview with Maintenance Supervisor revealed the facility was using a flame-retardant spray used on all resident rooms' curtains in the facility. Observation and document review also revealed facility did not provide documentation for all resident room curtains and flame-retardant spray used on the resident rooms' curtains. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 4/4/23.	K 753	3. The maintenance Director was in-serviced on the importance of spraying all curtains before placement in rooms and accurate record keeping by the Administrator on April 10, 2023. The Maintenance Director, Social Service Director and the Administrator will monitor all decorations being brought into the facility to ensure they are flame retardant or need to be treated with an approved NFPA flame retardant spray treatment. Any adverse findings will be taken to the Quality Assurance Committee. 4. The Maintenance Director, Social or the Administrator will report any adverse findings to the Quality Assurance Committee weekly for three weeks, then monthly for two months, then quarterly for a year.	