

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

PRINTED: 06/23/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER TISHOMINGO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 230 KHAKI STREET IUKA, MS 38852		
(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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain exit egress in the corridor as per NFPA 21.2.1, This deficiency affected four (4) of five (5) smoke compartments in the facility all 100 residents in the facility on the day of survey. Findings include: On 5/24/23 at 11:50 AM observation revealed folded, mounted keyboards (at the computer screens) obstructed the exit egress in the main corridor of the facility. The mounted keyboards extended beyond the	K 211	The mounted keyboards at the computer screens in the main exit corridors of the facility were removed on 5/24/23 by the Maintenance Director. All residents have the potential to be affected by this deficient practice. No residents were identified as being affected by this deficient practice. The Administrator in-serviced the Maintenance Director on 6/2/23 on checking the main exit corridors to ensure exit egress is without obstruction. A Quality Assurance Meeting was held on 5/30/23 to discuss findings from the survey exit and systematic changes needed to ensure the deficient practice	6/30/23	

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

TITLE

(X6) DATE

Electronically Signed

06/16/2023

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.

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

PRINTED: 06/23/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER TISHOMINGO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 230 KHAKI STREET IUKA, MS 38852		
(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 211	Continued From page 1 handrail and obstructed the main corridors to exit access of the facility. The keyboards were throughout the corridors of the facility.	K 211	does not reoccur. Beginning 6/5/22, the Administrator or Maintenance Director will check the main exit corridors to ensure exit egress is without obstruction weekly for four weeks, then monthly for three months. Beginning 6/12/23, the Administrator or Maintenance Director will report any concerns regarding K Tag 211 in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning 6/20/23, the Administrator or Director of Nursing will report any concerns at the Quality Assurance Committee Meeting, then monthly for three months until substantial compliance is achieved with K Tag 211. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with K Tag 211.		