STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255226	A. BUILDING _____ B. WING _____	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATCHEZ REHABILITATION AND HEALTHCARE CENTER	344 ARLINGTON AVENUE NATCHEZ, MS 39120

(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 State Survey Agency (SA) conducted an annual refortification survey at the facility from 11/27/2018 to 11230/2018. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited The the regulatory deficiency F638. At the time of survey the census was 52, and the facility held a license for 58 beds.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) Assessment in a timely manner for one (1) of 19 Resident MDS Assessments reviewed; Resident #1. Findings include: Record review revealed Resident #1's most recent Omnibus Budget Reconciliation Act (OBRA) MDS was an Annual assessment dated 07/25/18. Further review revealed Resident #1 did not have an OBRA Quarterly MDS assessment completed since the most recent Annual MDS with an ARD of 7/25/18.	F 638	1. Resident #1's Quaterly Minimum Data Set (MDS) assessment was completed and submitted by the MDS Coordinator on December 5, 2018. 2. All residents have the potential to be affected by this deficient practice. An Audit was conducted by the MDS Coordinator on December 1, 2018 for 52 residents on Minimum Data Set (MDS) to ensure that quarterly assessments were completed by using the quarterly review instrument specified by the states and approved by the Center for Medicaire and Medicaid Services no less than every three (3) months with no other issues noted. All assessments were in compliance.	12/31/18

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

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F 638	Continued From page 1 On 11/28/18 at 1:15 PM, an interview with the MDS Coordinator/Registered Nurse (RN), revealed she had completed an OBRA Quarterly MDS assessment since the most recent Annual MDS assessment with an ARD of 7/25/18. The MDS Coordinator stated, "I should have combined the Quarterly MDS with the Medicare 5-Day MDS assessment, no I do not have one done (referring to the Quarterly MDS)." On 11/29/18 at 2:35 PM, an interview with the Director of Nursing (DON), revealed she would expect the MDS nurse to complete the MDS because she is in charge of the MDS, and is the MDS Coordinator. The DON also stated she would expect the MDS nurse to let her know if she is running behind so she could get back-up help for her as needed. On 11/29/18 at 2:40 PM, an interview with the Administrator (Adm), revealed he would expect the MDS to be done within the regulatory period, and as timely as possible. A review of the facility's Face Sheet, revealed the facility admitted Resident #1, on 07/17/17, with diagnoses of Major Depressive Disorder, Bipolar, and Schizophrenia. The most recent Annual MDS assessment, with an Assessment Reference Date (ARD) of 07/25/18, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated no cognitive impairment.	F 638	3. The MDS Coordinator received education regarding regulatory requirement of completing MDS not less frequently than once every three (3) months on December 20, 2018 by Clinical Reimbursement Nurse. 4. The MDS Coordinator will print a weekly schedule of Minimum Data Sets (MDS) due from the Case Mix Report, beginning 11/28/18. The MDS Coordinator will utilize this schedule to ensure Minimum Data Sets(MDS) are completed according to schedule. The MDS Coordinator and Administrator will meet weekly and review the weekly schedule of Minimum Data Sets to ensure that Minimum Data Sets (MDS)have been completed for the week. The MDS Coordinator will report findings to Quality Assurance Performance committee for three (3) months for further recommendations. The Administrator is responsible for ongoing monitoring an compliance.	

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	255226	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2018**

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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 221 SS=D	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly maintain patient sleeping room doors as directed by NFPA Chapter 19.2.2.2.5. This deficiency affected one (1) of four (4) exits in the building and 24 of 52 of the residents in the facility on day of survey. Findings include: During fire alarm testing on November 28, 2018 at 10:40 AM, observation revealed the magnetic locking device on B Hall exit door did not release upon activation of the fire alarm system. The deficiency restricted and obstructed exit access through from the B Hall Wing of the facility. The finding was acknowledged by the	K 221	1. On November 29, 2018 fire exit door was repaired by contracted repair company. 2. 52 residents were potentially effected. 3. On November 28, 2018 the facility Maintenance Director was educated by the Administrator regarding regulatory requirements. 4. Beginning week of November 30, 2018 facility Maintenance Director will check fire doors weekly for four weeks then monthly thereafter to ensure doors release per requirement. Maintenance Director will report findings to Quality Assurance Performance committee monthly for three months for further recommendations. The Administrator is responsible or ongoing	12/31/18

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	255226	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2018**

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K 221	Continued From page 1 Administrator and Maintenance Supervisor during the exit interview on November 28, 2018.	K 221	monitoring and compliance Date of Compliance is November 29, 2018	

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

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 11/30/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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