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 _____	C 12/27/2023

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 a Complaint Investigation (CI MS # 23672) at the facility on 12/27/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F580 for Notification of Changes. At the time of survey the facility had a census of 47 residents and was licensed for 60 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		1/25/24

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

Electronically Signed | 01/05/2024

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on Resident Representative and staff interview, record review and facility policy review the facility failed to notify a Resident Representative of a change in status of a resident resulting in hospitalization for one (1) of three (3) residents reviewed with changes in mental/physical condition. Resident #1 Findings include: Review of the facility policy titled, "Change in a Resident's Condition or Status," revealed, "Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and	F 580	1. No immediate correction could be made for the residents family or representatives not being notified of residents change in condition. No immediate corrective action could be made for resident # 1's representative not being notified of a change in condition that resulted in resident #1 needing to be transported to the hospital. 2. Due to the potential for harm related to the deficient practice of failure to notify family or representative of change in status, all transfers over the last 3 months	

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F 580	Continued From page 2 representative (sponsor) of changes in the resident's medical/mental condition and/or status..." A phone interview with the Resident Representative (RR) for Resident #1 on 12/27/23 at 10:30 AM, revealed the hospital called him on 12/7/23 stating his dad was to be discharged at 10:00 AM and that he was admitted on 12/5/23 for changes in his mental status. He also revealed he was unaware that his dad had even been sent to the hospital, so he called and spoke with the Director of Nursing (DON) at the nursing home, and she stated she had called him herself. He said, "I had no missed calls from the facility." The RR for Resident #1 also stated "it is possible that the DON accidentally called the wrong number, but it does not change the fact that I was not notified and the staff at the nursing home should have continued to call until they reached me." Review of the departmental notes revealed on 12/05/23 at 9:17 AM Resident #1 was observed slouched in wheelchair, and unable to follow simple commands ... 9:38 AM Attempted to notify RR ... 9:42 AM Resident departed the facility via stretcher ... An interview with the Administrator on 12/27/23 at 12:00 PM, revealed after review of Resident #1's departmental notes dated 12/5/23, the DON attempted to notify the resident's RR of the change in status and confirmed that there was no other documentation of continued attempts to notify the RR of the changes and transfer to the hospital. The Administrator confirmed staff should have continued to attempt to contact the RR and document the attempts. The Administrator's	F 580	were audited on 1/4/24 and 1/5/24 by the Director of Nurses and Medical Records Nurse. It was determined that no other residents were affected by deficient practice as evidenced by documentation of family or representative notification of transfer was present on all audited charts. 3. On 12/28/23, Administrator in serviced Director of Nurses on notification of resident families or representatives of changes in residents medical/mental condition and/or status and subsequently Director of Nurses in serviced 14 of 18 licensed nurses on notification of resident families or representatives of changes in the residents medical/ mental condition and / or status, on 12/28/2023. All other nurses in serviced prior to their next shift worked. In servicing completed on 1/5/24. On 1/5/24, the Quality Assurance team reviewed the "Change in Resident's Condition or Status" policy with no recommendations for changes. 4. On 12/28/23, Medical Records Nurse began auditing acute book on Monday-Friday's for transfers to hospital with Nurse Nurses notes in Medical Record to ensure documentation of notification of transfers to family or representative. These audits will be on-going and Medical Records Nurse was in serviced on 1/8/24 to report findings of audit in the morning stand-up meetings. On 01/08/2024 morning stand up meeting minutes were edited to include "# of acute transfers' and "documentation of notification to families/representatives	

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F 580	Continued From page 3 concern that the family was not informed of a change in status and may not be notified of further declines from no follow-up by staff. An interview with the DON on 12/27/23 at 12:30 PM, revealed she had assessed Resident #1 and received an order for transport to the hospital related to Altered Mental Status and confirmed she had attempted to contact the RR at the time of transfer to the hospital but did not get an answer. The DON then stated, "I dropped the ball and did not attempt to contact the RR again and assumed the floor nurse would have continued to try to notify the family." A phone interview with Licensed Practical Nurse #1 on 12/27/23 at 12:55 PM, she confirmed she was the nurse for Resident #1 on 12/5/23 when he was transported out for Altered Mental Status, and revealed she was unaware that the DON did not reach the RR and she assumed the RR was notified as she was not instructed to follow-up. Review of the Face Sheet revealed the facility admitted Resident #1 on 1/06/23 with a diagnosis of Cerebral Infarction. Review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/23 for Resident #1, revealed Section A-2105: Discharge Status: Short-Term General Hospital ... Section C-1310A: Acute onset of Mental Status Change-Yes ...	F 580	verified". On 1/8/24 "Notification of Transfer Log" tool will be implemented to record call and number of attempts to call families or representatives when residents transfer to the hospital. Director of Nurse or Nurse Manager will check log for completion weekly x's 4 weeks, then bi-weekly for 3 months. Emergency Quality Assurance meeting held on 1/5/24 and "Notification of Resident Change in Status" added to ongoing Quality Assurance Committee monitoring. Follow up Quality Assurance meeting to be held 1/25/24 and will be quarterly thereafter. 5. The corrective action will be completed by 1/25/23	