STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey along with Complaint Investigations (CI) 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 the Minimum Standards for Institutions for Aged or Infirm,state licensure requirements with a deficiency cited at M 815. Anonymous reported CI # 20783 for accidents, visitation, dietary and activities of daily living (ADL'S) was investigated and M500 was cited . CI #20619 for staffing, and medications was investigated and no deficiencies were cited related to this complaint. Census at the time of survey was 46 and the facility had beds for 60 residents.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		5/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 500	Continued From page 2 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 500	Continued From page 4 This Statute is not met as evidenced by: Level II 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 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	M 500	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 500	Continued From page 5 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. 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	M 500	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
	72TC	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) COMPLETE DATE
M 500	Continued From page 6 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.	M 500		
M 815 SS=F	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II 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.	M 815	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.	5/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	72TC	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) COMPLETE DATE
M 815	Continued From page 7 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. 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	M 815	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. 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
	72TC	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) COMPLETE DATE
M 815	Continued From page 8 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 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.	M 815		