TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING B. WING	3	DATE SURVEY COMPLETED
		25G003	B. WING		02/04/2011
	ROVIDER OR SUPPLIER	ICF/MR	96	EET ADDRESS, CITY, STATE, ZIP CODE 57 REGIONAL CENTER DRIVE XFORD, MS 38655	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
W 104	483.410(a)(1) GO The governing boo budget, and opera	VERNING BODY dy must exercise general policy, tting direction over the facility.	W 104	Female Group Home–Boonevill 1. Floors were stripped and wax on 03/01/11. Baseboards were a stripped.	ed 03/01/1
	Based on observa facility failed to ma and two (2) refrig	is not met as evidenced by: tion, and staff interview, the aintain the physical environment erators were in good repair in		Floor burnishers purchased for a homes on 01/11/11 and delivere homes the last 2 weeks of 02/11	d to
	water temperature one (1) of 19 grou	es, and failed to ensure that hot es were in acceptable ranges in p homes.		 Rust was removed through sanding and an approved paint applied. A special plastic, rust p and waterproof composite liner 	
	a.m. with the Hous group home (Boo build-up stains on areas throughout refrigerator's large eggs, revealed the and had rust color House Supervisor inside of the refrig colored spots. The the thick brownish throughout the ho	e initial tour on 2/3/11 at 11:59 se Supervisor in the female neville) revealed thick brownish the floor thresh holds and wall the house. The inside of the e compartment, storing milk and e bottom white area was peeling red spots. An interview with the confirmed the bottom area gerator was peeling and had rust he House Supervisor stated that h build-up stains on the floor use was due to the staff waxing d didn't have the proper		permanently installed.	
	House Supervisor (Booneville)revea refrigerator's large eggs, had rust co the House Superv	/3/11 at 12:20 p.m. with the r in the male home led the inside of the e compartment, storing milk and lored spots. An interview with visor confirmed the inside of the m area had rust colored spots.		Male Group Home–Booneville Appliance replaced. Appliances in other homes were inspected for similar problems.	02/22/1

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DEPART		HAND HUMAN & .VICES			PRINTED: 02/24 FORM APPRO OMB NO: 0938-	OVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		X3) DATE SURVEY COMPLETED	
		25G003	B. WING		02/04/2011	
NAME OF PF	OVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 37 REGIONAL CENTER DRIVE		
NORTH N	IS REGIONAL CTR	ICF/MR		XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPL	(5) LETION ATE
W 104	that the common side of the male g water temperature Fahrenheit (F). T (5) minutes and th 80 degrees F. An interview on 2. House Director re- was on the opposi- took a very long ti- bathing. The Hou- water temperature staff during their re- there were no hot maintained in the An interview on 2 Maintenance Direc- took a long time to shower/bath beca	1/2011 at 3:00 p.m. revealed bath/shower area on the right roup home (Fulton) had a hot to that registered 80 degrees the hot water ran for at least five the temperature never exceeded 1/2011 at 3:00 p.m. with the vealed that the hot water tank ite side of the house and usually me to get warm enough for use Director stated that the hot es were taken by the security ounds in the mornings and that water temperature records home. /3/11 at 9:30 a.m. with the ector revealed that the hot water o get hot enough for a ause the hot water tank was on	W 104	<u>Male Group Home–Fulton</u> Requisition approved 03/01/1 plumb in a return circuit and install a continual circulation pump to provide hot water mo efficiently and timely.		25/11
W 327	the far side away the right side of the Director stated the tankless hot wate house.	from the bath/shower area for ne house. The Maintenance at they may consider putting in a er system for that side of the PHYSICIAN SERVICES	W 327	Tuberculosis control will be maintained through the admis	Entrol 1	31/11
	examinations of includes tubercul facility's population recommendation Chest Physicians	provide or obtain annual physical each client that at a minimum osis control, appropriate to the on, and in accordance with the s of the American College of s or the section on diseases of American Academy of Pediatrics,		chest x-ray and yearly tubercu skin test. Individuals who convert to a positive skin test (induration 10mm) will be referred to the NMRC licensed heath care provider for a chest x-ray.	ulin of>	

Event ID: BTCX11

Facility ID: MSN4QX

If continuation sheet Page 2 of 8

Skogus 3-8-11

	TMENT OF HEALTH	HAND HUMAN VICES			FORM	02/24/2011 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		25G003	B. WING		02/0	4/2011
			9	REET ADDRESS, CITY, STATE, ZIP COE 67 REGIONAL CENTER DRIVE	θE	
NORTH	MS REGIONAL CTR		C	XFORD, MS 38655		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 327	This STANDARD Based on observa interview, the facili documentation of positive tuberculin of 49 clients (Clien Findings include: Record review rev diagnosis of Profo Observation on 2/ not verbal and use gestures to comminteracting in a cla clients and two (2) Record review rev positive tuberculin Record review did and/or the measu tuberculin skin test documentation as actually converted test screening. The of the positive tuber to f the positive tube not documented for An interview on 2/ Director of Nursin facility had no doc measurements, a positive tuberculin confirmed that the annual signs and DON stated that the annual signs and	is not met as evidenced by: tion, record review, and staff ity failed to obtain annual signs and symptoms for a skin test screening for one (1) at #5). ealed that Client #5 had a und Mental Retardation. 3/11 revealed that Client #5 was ed some sign language and unicate. Client #5 was assroom with several other o staff members. realed that Client #5 had a skin test screening in 2003. not reveal the induration, rements of the positive at screening. There was no to the actual date that Client #5 to a positive tuberculin skin he facility's follow up procedure erculin skin test screening was	W 327	Upon completion of the chex-ray, the client will be referent local health department. The recommendations and/or of health department physicial carried out to include INH the any required laboratory more the duration of the therapy client's chart will be flagged previous positive tuberculine the client will no longer receannual tuberculin test. Individuals with a previous tuberculine test will be evaluation form (see attack Questionnaire for Previous evaluation form (see attack client is negative for signs symptoms of tuberculosis, immediate referral will be relicented to the annual TB Question Previous Positive form by clients with a previous positive form by clients with a previous positive evaluation previous Positive form by clients with a previous positive annual TB Question Previous Positive evaluation by the staff no later than 03/11/11 Client Annual TB Question Previous Positive evaluation by the staff no later than 03/11/11 Client Annual TB Question Previous Positive evaluation by the staff no later than 03/11/11 Client Annual TB Question Previous Positive evaluation by the staff no later than 03/11/11 Client Annual TB Question Previous Positive evaluation by the staff no later than 03/11/11 Client Annual TB Question previous Positive evaluation by the staff utilizing the Client Annual Procedures and performed annually. See IP Policies and Procedures and	rred to the rhe orders of the an will be therapy and onitoring for 7. The d as a n test, and eive an positive nated Annual TB Positive hed). If the and an made to the der. will be n of the maire for 3/31/11. All itive will he Nursing I utilizing the maire for on form (see evaluation NMRC ttached. ed and he the Nursing nual TB pre negative	

Event ID: BTCX11

Facility ID: MSN4QX

8 continuation sheet i

Stogers-11 3.8-11

TATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S COMPL	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG		
		25G003	B. WING		02/0	04/2011
				REET ADDRESS, CITY, STATE, ZIP COD 67 REGIONAL CENTER DRIVE	•	
NORTH	MS REGIONAL CTR	ICF/MR	C	DXFORD, MS 38655		-
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 327	screenings. The D no policy and proc positive tuberculin The facility did not for the annual doc	age 3 ON stated that the facility had redure for the follow-up of a skin test screening. Thave a policy and procedure umentation for signs and positive tuberculin skin test	W 327			
W 339	screenings. 483.460(c)(4) NUI Nursing services r as prescribed by t client needs. This STANDARD Based on observa interview, the facil client with a 25 pc manner or one (1) Findings include: Record review rev admitted to the fa which included Ma Profound Mental Spastic Quadripa Fusion, Hypertens Constipation. Review of the wei 136.8 pounds in 1 a weight of 110.7 25.3 pound weigh (DON) reweighed weight was 116 p weight loss. The	RSING SERVICES must include other nursing care he physician or as identified by is not met as evidenced by: ation, record review, and staff ity failed to properly address a und weight loss in a timely of 49 clients (Client #45). vealed that Client #45 was cility on 1/10/80 with diagnoses ajor Depressive Disorder, Retardation, Cerebral Palsy, resis Post-Operative Lumbar sion, Seizure Disorder and ght record revealed a weight of 1/10, 136 pounds in 12/10, and pounds in 1/11. This was a t loss. The Director of Nursing Client #45 on 2/3/11 and the ounds. This was a 20 pound only documentation that was this apparent weight loss was	W 339	Heights and weights on a will be monitored on a re- basis. Monthly weights weights obtained on all clients by evening shift Nursing stat Individual growth record maintained on each client medical record. Significat changes in growth pattern be referred to the physici- licensed healthcare profe and the Nutrition Service department. Referrals we documented in the nurses More frequent measurem be obtained on those clies have experienced significat changes in either height of weight. These measurem be taken and shared with physician or licensed heat provider and the Nutrition Services department unti- client's condition stabiliz- improves.	gular will be the ff. s will be t's ant ns will an or ssional ssill be s notes. tents will nts who cant or nents will the lth care n l the	03/31/1

Event ID: BTCX11

Facility ID: MSN4QX

If continuation sheet Page 4 of 8

frogue 3-8-11

DEPARTMENT OF HEALTH AND HUMAN VICES

DENTE	RS FOR MEDICAR	= & MEDICAID SERVICES				ONR NO.	0938-0391
Constrainty 2 Manual States And States	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003	(X2) N A. BU B. WI	ILDIN		(X3) DATE SI COMPLE	
		236003	1	r		02/0	4/2011
	PROVIDER OR SUPPLIER	CF/MR		96	EET ADDRESS, CITY, STATE, ZIP CODE 67 REGIONAL CENTER DRIVE 0XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 339	on 1/25/11 when C p.m. was changed provide more calor Record review reve Practitioner charter 136 # (name of Cli recent changes in with plan." The Ne of the weight loss. observed from the Practitioner was no 1/7/11. There was physician had been Record review reve Regular, chopped liquids. Alternate b Also, ordered was (cc) mixed with 30 a.m. and at night, a 1 Packet in 6 to 8 d a day at 12 noon a supplements were Administration Rec no documentation ingested. An interview with the did not receive the of the month and a be address as soon An interview with th	theetos that were given at 3:00 to oatmeal crème pie to ies. ealed that on 1/7/11 the Nurse d in the progress notes "Wt. ent #45) is doing well. No medical issues will proceed urse Practitioner was not aware No further documentation was Nurse Practitioner. The Nurse of aware of the weight loss on no documentation that the n notified. ealed that Client #45 was on a diet with honey-thickened bites of food with sips of liquid. Promod 30 cubic centimeters cc of water 2 times a day at 8 and Juven Nutritional Drink mix punces of water or juice 2 times nd at 5 p.m. These documented on the Medication ford that they were given, but as the amount the client the Registered Dietitian (RD) on a.m. revealed there was no forerning this apparent weight ed that she thought something e scales. The RD stated she weights until about the middle 25 pound weight loss needs to	W	339	referral of significant change growth patterns of clients to physician or licensed healtho provider and the Nutrition So department by 3/31/11. Client #45 was placed on we weight monitoring. The wee weights obtained thus far are follows: 2/10/11 – 116.6 po 2/17/11 – 116.8 pounds, and 2/24/11 – 121.4 pounds. For were also put in place to doc his intake on 2/7/11. An add snack was added to his diet a A member of the Nutrition So department continues to mee client #45 to provide substitu- his meal preferences. His id weight range is 94 pounds – pounds. All scales were checked for accuracy. Scales must be ze before you can weigh anothe All other clients in this cotta re-weighed to determine acc See NMRC Policies and Pro- attached. 17.4.19	the care ervices eekly ekly e as unds, od logs eument ditional as well. Services et with utes for eal body 115 roed out er client. ege were uracy.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BTCX11

Facility ID: MSN4QX

If continuation sheet Page 5 of 8

Skogens 3-9-11

DEPARTMENT OF HEALTH AND HUMAN *VICES*

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003	(X2) M A. BUI B. WIN	LDING	Col	TE SURVEY MPLETED	
	PROVIDER OR SUPPLIER			967	ET ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655	2 See 1941	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 339 W 455	scales. The DON appear to have los still fit him. Record review rev documented on 1/ still no documenta weight loss. 483.470(I)(1) INFE There must be an prevention, contro and communicable This STANDARD Based on observa facility failed to ma measures to preve	thing was wrong with the stated that the client did not at weight and that his clothes ealed the weight loss was 6/11. 30 days later, there was tion concerning the apparent ECTION CONTROL active program for the I, and investigation of infection	W 3		All Education staff will be in-serviced in the area of infection control including, but not limited to, proper handling of client food. Staff will be instructed to never place food on the floor.	03/31/11	
	had diagnoses wh Retardation, Histo Seizure Disorder. Unsampled Client snack time sitting teacher allowed th donut from a plast the plastic contain foster grandparent her seat to assiste behavior problems juice from a cup. T	ealed that Unsampled Client A ich included Profound Mental ry of Autistic Disorder and On 2/1/11 at 10:20 a.m. A was observed in class during in a chair with a desk. The e client to get one (1) small ic container then she placed er on the floor next to the male t chair. The teacher returned to d a male client with pervious is in the classroom with drinking The Foster Grandparent allowed A to get one (1) donut from the			All Foster Grandparents will be in-serviced in the area of infection control including, but not limited to, proper handling of client food. Foster Grandparents will be instructed to never place food on the floor.	03/07/1	

Skoger 11 3-8-11

PRINTED: 02/24/2011 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN RVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 25G003 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 967 REGIONAL CENTER DRIVE NORTH MS REGIONAL CTR ICF/MR **OXFORD, MS 38655** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 455 Continued From page 6 W 455 plastic container then he placed the container on the floor. This behavior continued two (2) more times until the plastic container was empty. Then the Foster Grandparent placed the plastic container on the counter next to the sink. An interview with the male Foster Grandparent revealed Unsampled Client A's donuts were in a plastic container because he eats too fast. An interview on 2/4/11 at 9:45 a.m. with the Teacher/Qualified Mental Retardation Professional (QMRP) confirmed that she placed Unsampled Client A's donuts in the plastic container on the floor and this was the wrong thing to do. The Teacher/QMRP stated that the client's donuts were in a plastic container because he usually put all of the donuts in his mouth at one time. W 460 Twin Oaks W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES Twin Oaks staff were in-serviced on 02/14/11 the specific needs of client #18 as Each client must receive a nourishing, well as supplements and the well-balanced diet including modified and importance of following the diet specially-prescribed diets. plans. This STANDARD is not met as evidenced by: NMRC Policies and Procedures. Based on observation, staff interview and record Vo. III, 18.4.6.2 "Diet list will be review, the facility failed to provide a nutritional prepared by the dietician to notify supplement as ordered by the physician for one (1) of 49 clients during a lunch meal observation the cottages of each diet to be served (Client #18). the clients." 18.4.6.2.1 "The diet list will include each client's name Findings include: and prescribed meal plan, Record review revealed that Resident #18 had nourishments, an other information diagnoses which included Severe Mental and will be updated monthly." Retardation, Osteoporosis, Scoliosis, Hypertension and Chronic Wound (Right Elbow).

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BTCX11

Facility ID: MSN4QX

If continuation sheet Page 7 of 8

SRoger 11

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

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES				OMB NO	. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003		ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		256005				02/0	4/2011
	ROVIDER OR SUPPLIER	ICF/MR		96	EET ADDRESS, CITY, STATE, ZIP CODE 7 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	570.07	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 460	Observation on 2/3 meal revealed Res Pudding Suppleme Review of the phys revealed a diet ord Plus at lunch and B and 3:00 p.m. snac An interview on 2/3 Qualified Mental R (QMRP) regarding the supplement for staff saw the order pudding. The QMF miss read by the st Review of the Nutri Boost Pudding with proteins and the Bo calories and 14 pro	 B/11 at 11:30 a.m. of the lunch sident #18 eating a Boost ent with the lunch meal. Sician's orders for January 2011 er for Ensure Plus or Boost Boost Pudding at 10:00 a.m. ck. B/11 at 1:50 p.m. with the etardation Professional the lunch meal concern with Resident #18 revealed the for Boost and assumed it was RP revealed the order was a ff. Ition information revealed a 240 calories and seven (7) post Plus calories with 360 	W	460			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BTCX11

Facility ID: MSN4QX

If continuation sheet Page 8 of 8

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PRINTED: 02/24/2011 FORM APPROVED OMB NO 0938-0391

TATEMEN	T OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G 01 - WOODLEA BUILDINGS	(X3) DATE S COMPLE	
		25G003	B. WING		02/0	4/2011
	PROVIDER OR SUPPLIER	CF/MR	96	EET ADDRESS, CITY, STATE, ZIP CODE 57 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	42 CFR 483.70(a) The facility must m the 2000 (existing)	TS eet the applicable provisions of Edition of the Life Safety Code nal Fire Protection Association	K 000			Waiver
K 146	NFPA 101 LIFE SA A nursing home or equipment has an separate and indep source that will be hour after loss of th 3.6.3.1.1 This STANDARD is The facility failed to panel to monitor the generator serving t	AFETY CODE STANDARD hospice with no life support alternate source of power bendent from the normal effective for minimum of 1½ he normal source. NFPA 99, s not met as evidenced by: o provide a remote annunciator e Type 10, Class X, Level 2 he Type 2 Essential Electrical	K 146	Due to age and physical locat specially designed and fabrica annunciators and a communic network will need to be desig fabricated, and installed. All required status sensors wit to be adapted to our 30 yr. old Research and design has begy Thompson Power Co. The communication system is developed by an electrical co	ated cation gned, ill have d units. un with s being	request for 365 days has been submitted
	the surveyor and th observed there to b the operational stat generators at a stat facility. Specific Code: Nati Associations's (NFF 1999 Edition. 3-6.1. Sources (Typ source of power for specifically designe	on 2/1/11 at appx. 11:53 a.m., e maintenance supervisor be no provision for monitoring us of the three emergency ffed remote location within the onal Fire Protection PA) 99, Health Care Facilities, be 3 EES). The alternate the system shall be d for this purpose and shall be system, or self-contained		and communications contract Due to the time and expense involved to complete this pro application for a waiver has b submitted. (See attached)	oject,	1. m

STATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING 01 - WOODLEA BUILDINGS	COMPLE	IED
		25G003	B. WING		02/0	4/2011
NAME OF F	PROVIDER OR SUPPLIER	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTH	MS REGIONAL CTR	ICF/MR		967 REGIONAL CENTER DRIVE OXFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 146	battery integral wit Generators shall c On-Site Generator 3-4.1.1.4(b) Type I power sources (pri as Type 10, Class 3-4.1.1.15 Alarm A annuciator, storage provided to operator room in a location personnel at a regu 70, National Electr The Annunciator s the emergency or a follows: (a) Individual visua following: 1. When the er source is operating to 2. When the er source is operating to 2. When the ba (b) Individual visua audible signal to warn of an engine- indicate the following: 1. Low lubricati 2. Low water te required in 3-4.1.1.9) 3. Excessive w 4. Low fuel - wh contains less than a 3-hou 5. Overcrank (f 6. Overspeed	h the equipment. 3-6.1.1 onform to 3-4.1.1. 3-4.1.1. Set 3-4.1.1.4 General. Il essential electrical system ime movers) shall be classified X, Level 2 generator set. Annuciator. A remote e battery powered, shall be e outside of the generating readily observed by operating ular work station (see NFPA ical Code, Section 700-12.) hall indicate alarm conditions of auxiliary power source as I signals shall indicate the mergency or auxiliary power supply power to load attery charger is malfunctioning. I signals plus a common generator alarm condition shall mg oil pressure imperature (below those atter temperature hen the main fuel storage tank r operating supply	K 14	Due to see ou debusical la	ricated nication signed, will have old units. egun with n is being contractor actor. se project,	Waiver request fo 365 days has been submitted

Event ID: BTCX21

Facility ID: MSN4QX

If continuation sheet Page 2 of 3

Akoque 3-8-11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01 - WOODLEA BUILDINGS	COMPL		
		25G003	B. WING		02/	04/2011	
	ROVIDER OR SUPPLIER		967	ET ADDRESS, CITY, STATE, ZIP CO REGIONAL CENTER DRIVE FORD, MS 38655		02/04/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
K 146	at a continuously in derangement sign conditions in 3-4.1	age 2 ely labeled, shall be established monitored location. This al shall activate when any of the .1.15(a) and (b) occur, but nese conditions individually.	K 146				

Stogers 3-8-11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003	(X2) MULTIF A. BUILDING B. WING		(X3) DATE SU COMPLE	URVEY TED 4/2011
	ROVIDER OR SUPPLIER	CF/MR	96	EET ADDRESS, CITY, STATE, ZIP CODE 57 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 000			
	42 CFR 483.70(a)	a in the set	4			
	the 2000 (existing)	eet the applicable provisions of Edition of the Life Safety Code nal Fire Protection Association				
K 146	(NFPA) NFPA 101 LIFE SA	AFETY CODE STANDARD	K 146	Due to age and physical loca specially designed and fabric		
	equipment has an separate and indep source that will be	hospice with no life support alternate source of power bendent from the normal effective for minimum of 1½		annunciators and a commun network will need to be desi fabricated, and installed.	ication	for 365 days ha been submitte
	3.6.3.1.1 This STANDARD	ne normal source. NFPA 99, is not met as evidenced by:		All required status sensors w to be adapted to our 30 yr. of Research and design has beg Thompson Power Co.	ld units.	
	panel to monitor th generator serving t System.	o provide a remote annunciator e Type 10, Class X, Level 2 he Type 2 Essential Electrical	28	The communication system developed by an electrical co and communications contrac	ontractor	
	the surveyor and the observed there to be the operational state	on 2/1/11 at appx. 11:53 a.m., ne maintenance supervisor be no provision for monitoring tus of the three emergency ffed remote location within the		Due to the time and expense involved to complete this pro- application for a waiver has submitted. (See attached)	oject,	
	Specific Code: Nat Associations's (NF 1999 Edition. 3-6.1. Sources (Ty source of power fo specifically designed	ional Fire Protection PA) 99, Health Care Facilities, pe 3 EES). The alternate r the system shall be ed for this purpose and shall be y system, or self-contained				

STATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) M	JLTIPLE	CONSTRUCTION	(X3) DATE S	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	02 - WOODLANE BUILDINGS		
		25G003	B. WIN	G	***	02/	04/2011
10 10 10 T T T A A	ROVIDER OR SUPPLIER			STREET 967 F OXF			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 146	Generators shall of On-Site Generato 3-4.1.1.4(b) Type power sources (pri as Type 10, Class 3-4.1.1.15 Alarm / annuciator, storag provided to operation personnel at a reg 70, National Electri The Annunciator so the emergency or follows: (a) Individual visua following: 1. When the e source is operating to 2. When the b (b) Individual visua audible signal to warn of an engine indicate the following: 1. Low lubricat 2. Low water to required in 3-4.1.1.9) 3. Excessive w 4. Low fuel - w contains less than a 3-hou 5. Overcrank (6. Overspeed	th the equipment. 3-6.1.1 conform to 3-4.1.1. 3-4.1.1. r Set 3-4.1.1.4 General. III essential electrical system ime movers) shall be classified X, Level 2 generator set. Annuciator. A remote e battery powered, shall be the outside of the generating readily observed by operating ular work station (see NFPA rical Code, Section 700-12.) shall indicate alarm conditions of auxiliary power source as al signals shall indicate the mergency or auxiliary power supply power to load attery charger is malfunctioning. al signals plus a common -generator alarm condition shall ing oil pressure emperature (below those water temperature hen the main fuel storage tank ur operating supply	K 1	46			

Event ID: BTCX21

Facility ID: MSN4QX

If continuation sheet Page 2 of 3

Skoger 3-8-11

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WOODLANE BUILDINGS B. WING		(X3) DATE SURVEY COMPLETED		
		25G003			02/	02/04/2011	
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COU 967 REGIONAL CENTER DRIVE OXFORD, MS 38655	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
K 146	at a continuously i derangement sign conditions in 3-4.1	page 2 ely labeled, shall be established monitored location. This hal shall activate when any of the .1.15(a) and (b) occur, but hese conditions individually.	K 146				

Stogen 11

	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE S COMPL	SURVEY ETED
		25G003	B. WING		02/04/2011	
	ROVIDER OR SUPPLIER	CF/MR	9	REET ADDRESS, CITY, STATE, ZIP COD 267 REGIONAL CENTER DRIVE DXFORD, MS 38655	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	42 CFR 483.470(j)					
	2000 (existing) Edi	he applicable provisions of the tion of the Life Safety Code nal Fire Protection Association				
	There were no LSC survey.	C deficiencies cited during this				
ORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 04 - QUAIL RUN (WOMEN)	(X3) DATE SURVEY COMPLETED	
		25G003	B. WING		02/04/2011	
	ROVIDER OR SUPPLIER		967	ET ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	ITS	K 000			
	42 CFR 483.470(j))				
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association				
	There were no LS survey.	C deficiencies cited during this				
						1

ATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	URVEY ETED
		25G003	A. BUILDING	07 - BODOCK GROVE (MEN)	02/04/2011	
AME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	02/0	4/2011
IORTH N	IS REGIONAL CTR	ICF/MR	10	7 REGIONAL CENTER DRIVE (FORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	ITS	K 000			
	42 CFR 483.470(j)				
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association				
	There were no LS survey.	C deficiencies cited during this				
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BATORY	DIRECTOR'S OR PROV	IGER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		(X3) DATE S COMPL	SURVEY ETED
		25G003	B. WING	G 08 - BODOCK GROVE (WOME	02/04/2011	
			96	EET ADDRESS, CITY, STATE, ZIP CODE 57 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	TS	K 000			
	42 CFR 483.470(j)					
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association				
	There were no LSO survey.	C deficiencies cited during this				
a di seconda a di se						
						(X6) DATE
DRATORY	DIRECTOR'S OR PROVI	DERISUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		R-8-11

ATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	URVEY ETED
		25G003	A. BUILDING 09 - JAMES W. MANN (WOME) B. WING		02/04/2011	
	ROVIDER OR SUPPLIER		96	EET ADDRESS, CITY, STATE, ZIP CODE 7 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(FACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	NTS	K 000			
	42 CFR 483.470(j)				
	2000 (existing) Ed	the applicable provisions of the lition of the Life Safety Code anal Fire Protection Association				
	There were no LS survey.	C deficiencies cited during this				
				TITLE		(X6) DATE
RATOR	1 /1 /	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		3	~

ATEMENT		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 10 - JAMES W. MANN (MEN)	(X3) DATE S COMPL	SURVEY ETED	
		25G003	B. WING		02/04/2011		
	ROVIDER OR SUPPLIER		9	REET ADDRESS, CITY, STATE, ZIP CODE 67 REGIONAL CENTER DRIVE DXFORD, MS 38655	NTER DRIVE		
(X4) ID PREFIX TAG	(FACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
K 000	INITIAL COMMEN	NTS	K 000		34		
	42 CFR 483.470(j)					
	2000 (existing) Ec	the applicable provisions of the lition of the Life Safety Code anal Fire Protection Association					
	There were no LS survey.	C deficiencies cited during this					
DRATOR	Y DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE	
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TEMENT	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE S COMPL	
		25G003	B. WING		02/04/2011	
	ROVIDER OR SUPPLIER	CF/MR	9	REET ADDRESS, CITY, STATE, ZIP CODE 167 REGIONAL CENTER DRIVE DXFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	42 CFR 483.470(j)					
	2000 (existing) Edi	the applicable provisions of the tion of the Life Safety Code nal Fire Protection Association				
	There were no LSO survey.	C deficiencies cited during this				
RATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	3	(X6) DATE

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 12 - REDWOOD GROUP HON		(X3) DATE SURVEY COMPLETED	
		25G003	B. WING		02/04/2011	
	ROVIDER OR SUPPLIER	ICF/MR	96	EET ADDRESS, CITY, STATE, ZIP CODE 7 REGIONAL CENTER DRIVE KFORD, MS 38655	8	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ITS	K 000		*	
5	42 CFR 483.470(j)					
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association				
	There were no LSC survey.	C deficiencies cited during this				
	ě					
				TITLE		(X6) DATE
land	to a loc	IDER/SUPPLIER REPRESENTATIVE'S SIGN		Duric for on may be excused from correcting prov	3	-8-11

ATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	And a second second second second		(X3) DATE S COMPLE	URVEY ETED
DFLANO	CORRECTION		A. BUILDING 13 - FERNWOOD COMMUNIT		02/04/2011	
	ROVIDER OR SUPPLIER	25G003	STR	REET ADDRESS, CITY, STATE, ZIP CODE	02/0	4/2011
	IS REGIONAL CTR		9	67 REGIONAL CENTER DRIVE DXFORD, MS 38655		
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMENTS 42 CFR 483.470(j) The facility meets the applicable provisions of the 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).		K 000			
	There were no LS survey.	C deficiencies cited during this				
	Y DIRECTOR'S OR PROV			TITLE		(X6) DATE

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	URVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	ETED
			B. WING			
		25G003			02/0	4/2011
	ROVIDER OR SUPPLIER	ICF/MR	967	ET ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	42 CFR 483.470(j)					
	2000 (existing) Edi	the applicable provisions of the tion of the Life Safety Code nal Fire Protection Association				
	There were no LSO survey.	C deficiencies cited during this				
		이번 문화 문제				
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		2.0.0				
			1			
BATORY	DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
		mension Tatter (New York, NY 1977) (New York, 1977)		Duce for	ッ	-8-1

ATEMENT D PLAN C	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 15 - GLENDALE (MEN)	(X3) DATE SURVEY COMPLETED 02/04/2011	
		25G003	B. WING			
	ROVIDER OR SUPPLIER		967	ET ADDRESS, CITY, STATE, ZIP CO REGIONAL CENTER DRIVE (FORD, MS 38655	DE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	ITS	K 000			
	42 CFR 483.470(j)				
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association				
	There were no LS survey.	C deficiencies cited during this				
RATOR	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	. TITLE		(X6) DATE -8-//

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 16 - POPLAR POINT (WON B. WING			(X3) DATE SURVEY COMPLETED	
		25G003	B. WIN	G		02/0	04/2011
	ROVIDER OR SUPPLIER			967	T ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	250	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	КC	000			
	42 CFR 483.470(j)						
	2000 (existing) Ed	the applicable provisions of the ition of the Life Safety Code nal Fire Protection Association					
	There were no LS0 survey.	C deficiencies cited during this					
			ų.				
ORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE S COMPL	
ND PLAN C	FCORRECTION	DENTIFICATION NOMBER.	A. BUILDING 17 - POPLAR POINT (MEN)			
		25G003	B. WING		02/0	04/2011
	ROVIDER OR SUPPLIER	CF/MR	967	ET ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN 42 CFR 483.470(j)	TS	K 000			
	2000 (existing) Edi	he applicable provisions of the tion of the Life Safety Code nal Fire Protection Association				
	There were no LSC survey.	C deficiencies cited during this				
1	1 / //	FR/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	Darectos	3.	(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 18 - MEADOW VIEW E. COM.		(X3) DATE SURVEY COMPLETED		
	ROVIDER OR SUPPLIEF		96	EET ADDRESS, CITY, STATE, ZIP CODE 67 REGIONAL CENTER DRIVE 0XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMME	NTS	K 000	St. Carlos		
	42 CFR 483.470(j)				
	2000 (existing) Ed	the applicable provisions of the dition of the Life Safety Code onal Fire Protection Association				
	There were no LS survey.	C deficiencies cited during this				
	DIRECTOR'S OR PROV					(X6) DATE

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003			(X2) MULTI A. BUILDING B. WING	PLE CONSTRUCTION G 19 - MEADOW VIEW W COM. (DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER		96	EET ADDRESS, CITY, STATE, ZIP CODE 57 REGIONAL CENTER DRIVE XFORD, MS 38655			
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
K 000	2000 (existing) Ed (LSC) of the Natio (NFPA).		K 000				
ODATOD	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	Director		(X6) DATE 3-8-11	

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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

STATEMENT		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25G003	(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION 20 - TWIN OAKS "NORTH" CO	(X3) DATE SURVEY COMPLETED 02/04/2011	
	ROVIDER OR SUPPLIER		967	ET ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLE	ETION
K 000	2000 (new) Edition of the National Fire (NFPA).		К 000			
ABORATORY	DIRECTOR'S OR PROVI		ATURE	Director	(X6) DATE - S - S	

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.

PRINTED: 02/25/2011 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	02/25/2011
FORM	APPROVED
OMP NO	0038-0391

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN C	OF CORRECTION	25G003	A. BUILDING 21 - TWIN OAKS "SOUTH B. WING		" CO 02/04/2011	
	ROVIDER OR SUPPLIEI	R	967	T ADDRESS, CITY, STATE, ZIP CODE REGIONAL CENTER DRIVE FORD, MS 38655		
(X4) ID PREFIX TAG	VEACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	2000 (new) Edition of the National Fi (NFPA).		K 000			
K	V DIRECTOR'S OR PRO	DVIDER/SUPPLIER REPRESENTATIVE'S SIG	BNATURE	Dusctos	5	(X6) DATE 2-8-11

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES	1			0.0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDIN	G 22 - BRIAR RIDGE NORTH		
		25G003	B. WING		02/	04/2011
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 67 REGIONAL CENTER DRIVE		_
NORTH	IS REGIONAL CTR	ICF/MR	0	DXFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	NTS	K 000			
	42 CFR 483.470(j)				
	The facility meets the applicable provisions of the 2000 (new) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).					
41	There were no LS survey.	C deficiencies cited during this				
				Star Star		
						-
ODATOD		/IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE
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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 25G003		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION 23 - BRIAR RIDGE SOUTH	OUTH (X3) DATE SUF COMPLET	
	ROVIDER OR SUPPLIER		96	EET ADDRESS, CITY, STATE, ZIP CODE 7 REGIONAL CENTER DRIVE KFORD, MS 38655		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	ITS	K 000			
	42 CFR 483.470(j)				
	2000 (new) Edition	the applicable provisions of the n of the Life Safety Code (LSC) e Protection Association				
	There were no LS survey.	C deficiencies cited during this				
			14			
OPATOR		IDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	ТІТІЕ	_	(X6) DATE
JRATOR	DIRECTOR'S OR PROV	Kozus		Director	3	-8-11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	25G003		B. WING	24 - SENATOBIA GROUP HOM	02/	04/2011
	ROVIDER OR SUPPLIER		96	EET ADDRESS, CITY, STATE, ZIP CODE 7 REGIONAL CENTER DRIVE XFORD, MS 38655		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
К 000	2000 (new) Edition of the National Fir (NFPA).		K 000			
DATARY		DER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE		(X6) DATE