STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the physical environment and two (2) refrigerators were in good repair in two (2) of 19 homes, and failed to ensure that hot water temperatures were in acceptable ranges in one (1) of 19 group homes. Findings include: Observation on the initial tour on 2/3/11 at 11:59 a.m. with the House Supervisor in the female group home (Booneville) revealed thick brownish build-up stains on the floor thresh holds and wall areas throughout the house. The inside of the refrigerator's large compartment, storing milk and eggs, revealed the bottom white area was peeling and had rust colored spots. An interview with the House Supervisor confirmed the bottom area inside of the refrigerator was peeling and had rust colored spots. The House Supervisor stated that the thick brownish build-up stains on the floor throughout the house was due to the staff waxing the floor 11/10 and didn't have the proper equipment. Observation on 2/3/11 at 12:20 p.m. with the House Supervisor in the male home (Booneville)revealed the inside of the refrigerator's large compartment, storing milk and eggs, had rust colored spots. An interview with the House Supervisor confirmed the inside of the refrigerator bottom area had rust colored spots.	W 104	Female Group Home–Booneville 1. Floors were stripped and waxed on 03/01/11. Baseboards were also stripped. Floor burnishers purchased for all homes on 01/11/11 and delivered to homes the last 2 weeks of 02/11. 2. Rust was removed through sanding and an approved paint applied. A special plastic, rust proof and waterproof composite liner permanently installed. Male Group Home–Booneville Appliance replaced. Appliances in other homes were inspected for similar problems.	03/01/11 02/14/11 02/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

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W 104	Continued From page 1 Observation on 2/1/2011 at 3:00 p.m. revealed that the common bath/shower area on the right side of the male group home (Fulton) had a hot water temperature that registered 80 degrees Fahrenheit (F). The hot water ran for at least five (5) minutes and the temperature never exceeded 80 degrees F. An interview on 2/1/2011 at 3:00 p.m. with the House Director revealed that the hot water tank was on the opposite side of the house and usually took a very long time to get warm enough for bathing. The House Director stated that the hot water temperatures were taken by the security staff during their rounds in the mornings and that there were no hot water temperature records maintained in the home. An interview on 2/3/11 at 9:30 a.m. with the Maintenance Director revealed that the hot water took a long time to get hot enough for a shower/bath because the hot water tank was on the far side away from the bath/shower area for the right side of the house. The Maintenance Director stated that they may consider putting in a tankless hot water system for that side of the house.	W 104	Male Group Home–Fulton Requisition approved 03/01/11 to plumb in a return circuit and install a continual circulation pump to provide hot water more efficiently and timely.	03/25/11
W 327	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.	W 327	Tuberculosis control will be maintained through the admission chest x-ray and yearly tuberculin skin test. Individuals who convert to a positive skin test (induration of > 10mm) will be referred to the NMRC licensed heath care provider for a chest x-ray.	03/31/11

Skoglus 3-8-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 327	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to obtain annual documentation of signs and symptoms for a positive tuberculin skin test screening for one (1) of 49 clients (Client #5). Findings include: Record review revealed that Client #5 had a diagnosis of Profound Mental Retardation. Observation on 2/3/11 revealed that Client #5 was not verbal and used some sign language and gestures to communicate. Client #5 was interacting in a classroom with several other clients and two (2) staff members. Record review revealed that Client #5 had a positive tuberculin skin test screening in 2003. Record review did not reveal the induration, and/or the measurements of the positive tuberculin skin test screening. There was no documentation as to the actual date that Client #5 actually converted to a positive tuberculin skin test screening. The facility's follow up procedure of the positive tuberculin skin test screening was not documented for Client #5. An interview on 2/2/11 at 11:01 a.m. with the Director of Nursing (DON) revealed that the facility had no documentation as to the size, the measurements, and/or induration of Client #5's positive tuberculin skin test screening. The DON confirmed that the facility had not documented the annual signs and symptoms for Client #5. The DON stated that the facility had no policy and procedure for annual documentation of the signs and symptoms for the positive tuberculin skin test	W 327	Upon completion of the chest x-ray, the client will be referred to the local health department. The recommendations and/or orders of the health department physician will be carried out to include INH therapy and any required laboratory monitoring for the duration of the therapy. The client's chart will be flagged as a previous positive tuberculin test, and the client will no longer receive an annual tuberculin test. Individuals with a previous positive tuberculin test will be evaluated annually utilizing the Client Annual TB Questionnaire for Previous Positive evaluation form (see attached). If the client is negative for signs and symptoms of tuberculosis, an immediate referral will be made to the licensed health care provider. The Nursing Department will be in-serviced on the utilization of the Client Annual TB Questionnaire for Previous Positive form by 3/31/11. All clients with a previous positive will receive an evaluation by the Nursing staff no later than 03/11/11 utilizing the Client Annual TB Questionnaire for Previous Positive evaluation form (see attached) and will have an evaluation performed annually. See NMRC Policies and Procedures attached. Client #5's chart was flagged and he received an evaluation by the Nursing staff utilizing the Client Annual TB Questionnaire. Results were negative for signs and symptoms of TB.	

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W 327	Continued From page 3 screenings. The DON stated that the facility had no policy and procedure for the follow-up of a positive tuberculin skin test screening. The facility did not have a policy and procedure for the annual documentation for signs and symptoms of past positive tuberculin skin test screenings.	W 327		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to properly address a client with a 25 pound weight loss in a timely manner or one (1) of 49 clients (Client #45). Findings include: Record review revealed that Client #45 was admitted to the facility on 1/10/80 with diagnoses which included Major Depressive Disorder, Profound Mental Retardation, Cerebral Palsy, Spastic Quadriparesis Post-Operative Lumbar Fusion, Hypertension, Seizure Disorder and Constipation. Review of the weight record revealed a weight of 136.8 pounds in 11/10, 136 pounds in 12/10, and a weight of 110.7 pounds in 1/11. This was a 25.3 pound weight loss. The Director of Nursing (DON) reweighed Client #45 on 2/3/11 and the weight was 116 pounds. This was a 20 pound weight loss. The only documentation that was made concerning this apparent weight loss was	W 339	Heights and weights on all clients will be monitored on a regular basis. Monthly weights will be obtained on all clients by the evening shift Nursing staff. Individual growth records will be maintained on each client's medical record. Significant changes in growth patterns will be referred to the physician or licensed healthcare professional and the Nutrition Services department. Referrals will be documented in the nurses notes. More frequent measurements will be obtained on those clients who have experienced significant changes in either height or weight. These measurements will be taken and shared with the physician or licensed health care provider and the Nutrition Services department until the client's condition stabilizes or improves.	03/31/11

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W 339	Continued From page 4 on 1/25/11 when Cheetos that were given at 3:00 p.m. was changed to oatmeal crème pie to provide more calories. Record review revealed that on 1/7/11 the Nurse Practitioner charted in the progress notes "Wt. 136 # (name of Client #45) is doing well. No recent changes in medical issues will proceed with plan." The Nurse Practitioner was not aware of the weight loss. No further documentation was observed from the Nurse Practitioner. The Nurse Practitioner was not aware of the weight loss on 1/7/11. There was no documentation that the physician had been notified. Record review revealed that Client #45 was on a Regular, chopped diet with honey-thickened liquids. Alternate bites of food with sips of liquid. Also, ordered was Promod 30 cubic centimeters (cc) mixed with 30 cc of water 2 times a day at 8 a.m. and at night, and Juven Nutritional Drink mix 1 Packet in 6 to 8 ounces of water or juice 2 times a day at 12 noon and at 5 p.m. These supplements were documented on the Medication Administration Record that they were given, but no documentation as the amount the client ingested. An interview with the Registered Dietitian (RD) on 2/4/2011 at 11:08 a.m. revealed there was no documentation concerning this apparent weight loss. The RD stated that she thought something was wrong with the scales. The RD stated she did not receive the weights until about the middle of the month and a 25 pound weight loss needs to be address as soon as possible. An interview with the Director of Nursing on 2/4/11 at 10:00 a.m. revealed she had the same	W 339	referral of significant changes in growth patterns of clients to the physician or licensed healthcare provider and the Nutrition Services department by 3/31/11. Client #45 was placed on weekly weight monitoring. The weekly weights obtained thus far are as follows: 2/10/11 – 116.6 pounds, 2/17/11 – 116.8 pounds, and 2/24/11 – 121.4 pounds. Food logs were also put in place to document his intake on 2/7/11. An additional snack was added to his diet as well. A member of the Nutrition Services department continues to meet with client #45 to provide substitutes for his meal preferences. His ideal body weight range is 94 pounds – 115 pounds. All scales were checked for accuracy. Scales must be zeroed out before you can weigh another client. All other clients in this cottage were re-weighed to determine accuracy. See NMRC Policies and Procedures attached. 17.4.19	

S Rogers 3-8-11

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W 339	Continued From page 5 opinion that something was wrong with the scales. The DON stated that the client did not appear to have lost weight and that his clothes still fit him. Record review revealed the weight loss was documented on 1/6/11. 30 days later, there was still no documentation concerning the apparent weight loss.	W 339		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain infection control measures to prevent the potential spread of infection for one (1) unsampled client (Unsampled Client A). Findings include: Record review revealed that Unsampled Client A had diagnoses which included Profound Mental Retardation, History of Autistic Disorder and Seizure Disorder. On 2/1/11 at 10:20 a.m. Unsampled Client A was observed in class during snack time sitting in a chair with a desk. The teacher allowed the client to get one (1) small donut from a plastic container then she placed the plastic container on the floor next to the male foster grandparent chair. The teacher returned to her seat to assisted a male client with pervious behavior problems in the classroom with drinking juice from a cup. The Foster Grandparent allowed Unsampled Client A to get one (1) donut from the	W 455	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. 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.	03/31/11 03/07/11

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W 455	Continued From page 6 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 455		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide a nutritional supplement as ordered by the physician for one (1) of 49 clients during a lunch meal observation (Client #18). Findings include: Record review revealed that Resident #18 had diagnoses which included Severe Mental Retardation, Osteoporosis, Scoliosis, Hypertension and Chronic Wound (Right Elbow).	W 460	Twin Oaks Twin Oaks staff were in-serviced on the specific needs of client #18 as well as supplements and the importance of following the diet plans. NMRC Policies and Procedures, Vo. III, 18.4.6.2 "Diet list will be prepared by the dietician to notify the cottages of each diet to be served the clients." 18.4.6.2.1 "The diet list will include each client's name and prescribed meal plan, nourishments, an other information and will be updated monthly."	02/14/11

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W 460	Continued From page 7 Observation on 2/3/11 at 11:30 a.m. of the lunch meal revealed Resident #18 eating a Boost Pudding Supplement with the lunch meal. Review of the physician's orders for January 2011 revealed a diet order for Ensure Plus or Boost Plus at lunch and Boost Pudding at 10:00 a.m. and 3:00 p.m. snack. An interview on 2/3/11 at 1:50 p.m. with the Qualified Mental Retardation Professional (QMRP) regarding the lunch meal concern with the supplement for Resident #18 revealed the staff saw the order for Boost and assumed it was pudding. The QMRP revealed the order was a miss read by the staff. Review of the Nutrition information revealed Boost Pudding with 240 calories and seven (7) proteins and the Boost Plus calories with 360 calories and 14 proteins. An interview on 2/4/11 at 9:30 a.m. with the Registered Dietitian revealed the protein and calories were higher in the Boost Plus than in the Boost Pudding.	W 460		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 01 - WOODLEA BUILDINGS B. WING _____	02/04/2011

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 146	NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: The facility failed to provide a remote annunciator panel to monitor the Type 10, Class X, Level 2 generator serving the Type 2 Essential Electrical System. Findings include: During the survey on 2/1/11 at appx. 11:53 a.m., the surveyor and the maintenance supervisor observed there to be no provision for monitoring the operational status of the three emergency generators at a staffed remote location within the facility. Specific Code: National Fire Protection Associations's (NFPA) 99, Health Care Facilities, 1999 Edition. 3-6.1. Sources (Type 3 EES). The alternate source of power for the system shall be specifically designed for this purpose and shall be a generator, battery system, or self-contained	K 146	Due to age and physical locations, specially designed and fabricated annunciators and a communication network will need to be designed, fabricated, and installed. All required status sensors will have to be adapted to our 30 yr. old units. Research and design has begun with Thompson Power Co. The communication system is being developed by an electrical contractor and communications contractor. Due to the time and expense involved to complete this project, application for a waiver has been submitted. (See attached)	Waiver request for 365 days has been submitted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

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K 146	Continued From page 1 battery integral with the equipment. 3-6.1.1 Generators shall conform to 3-4.1.1. 3-4.1.1. On-Site Generator Set 3-4.1.1.4 General. 3-4.1.1.4(b) Type III essential electrical system power sources (prime movers) shall be classified as Type 10, Class X, Level 2 generator set. 3-4.1.1.15 Alarm Annuciator. A remote annuciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The Annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement	K 146	Due to age and physical locations, specially designed and fabricated annunciators and a communication network will need to be designed, fabricated, and installed. All required status sensors will have to be adapted to our 30 yr. old units. Research and design has begun with Thompson Power Co. The communication system is being developed by an electrical contractor and communications contractor. Due to the time and expense involved to complete this project, application for a waiver has been submitted. (See attached)	Waiver request for 365 days has been submitted

Akoya 3-8-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 01 - WOODLEA BUILDINGS B. WING _____	02/04/2011

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K 146	Continued From page 2 signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110:3-5.5.2]	K 146		

Rogers
3-8-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 02 - WOODLANE BUILDINGS B. WING _____	02/04/2011

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2000 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 146	NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: The facility failed to provide a remote annunciator panel to monitor the Type 10, Class X, Level 2 generator serving the Type 2 Essential Electrical System. Findings include: During the survey on 2/1/11 at appx. 11:53 a.m., the surveyor and the maintenance supervisor observed there to be no provision for monitoring the operational status of the three emergency generators at a staffed remote location within the facility. Specific Code: National Fire Protection Associations's (NFPA) 99, Health Care Facilities, 1999 Edition. 3-6.1. Sources (Type 3 EES). The alternate source of power for the system shall be specifically designed for this purpose and shall be a generator, battery system, or self-contained	K 146	Due to age and physical locations, specially designed and fabricated annunciators and a communication network will need to be designed, fabricated, and installed. All required status sensors will have to be adapted to our 30 yr. old units. Research and design has begun with Thompson Power Co. The communication system is being developed by an electrical contractor and communications contractor. Due to the time and expense involved to complete this project, application for a waiver has been submitted. (See attached)	Waiver request for 365 days has been submitted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers | TITLE: Director | (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 02 - WOODLANE BUILDINGS B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 146	Continued From page 1 battery integral with the equipment. 3-6.1.1 Generators shall conform to 3-4.1.1. 3-4.1.1. On-Site Generator Set 3-4.1.1.4 General. 3-4.1.1.4(b) Type III essential electrical system power sources (prime movers) shall be classified as Type 10, Class X, Level 2 generator set. 3-4.1.1.15 Alarm Annuciator. A remote annuciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The Annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement	K 146		

Skogus
3-8-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 02 - WOODLANE BUILDINGS B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 146	Continued From page 2 signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110:3-5.5.2]	K 146		

Rogers 3-8-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 03 - QUAIL RUN (MEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 04 - QUAIL RUN (WOMEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 07 - BODOCK GROVE (MEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers | TITLE: Director | (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 08 - BODOCK GROVE (WOME B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandy A. Rogers	Director	3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 09 - JAMES W. MANN (WOMEI B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 10 - JAMES W. MANN (MEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra W. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 11 - ELMWOOD COMMUNITY B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 12 - REDWOOD GROUP HOME B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A Rogers | TITLE: Director | (X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 13 - FERNWOOD COMMUNITY B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 14 - ROSEDALE (WOMEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 15 - GLENDALE (MEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 16 - POPLAR POINT (WOMEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra P. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 17 - POPLAR POINT (MEN) B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra D. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 18 - MEADOW VIEW E. COM. C B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 19 - MEADOW VIEW W COM. (B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra A. Rogers — TITLE: Director — (X6) DATE: 3-8-11

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 20 - TWIN OAKS "NORTH" CO B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy P. Rogers | TITLE: Director | (X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 21 - TWIN OAKS "SOUTH" CO B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 22 - BRIAR RIDGE NORTH B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy W. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 23 - BRIAR RIDGE SOUTH B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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 483.470(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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandy A. Rogers
TITLE: Director
(X6) DATE: 3-8-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25G003	A. BUILDING 24 - SENATOBIA GROUP HOM B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MS REGIONAL CTR ICF/MR	967 REGIONAL CENTER DRIVE OXFORD, MS 38655

(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. 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). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandy A. Rogers	Director	3-8-11

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.