STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255283	A. BUILDING _____ B. WING _____	07/12/2019

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VAIDEN COMMUNITY LIVING CENTER	868 MULBERRY STREET VAIDEN, MS 39176

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 7/9/19 to 7/11/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F656, F692, F758, and F925. At the time of the survey, the census was 50, and the facility held a license for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		8/2/19

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

Electronically Signed | 08/02/2019

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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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to implement/develop a comprehensive care plan related to nutrition and psychotropic medications (meds) for one (1) of 16 resident care plans reviewed, Resident #30. Findings include: A review of the facility's "Care Plan-Comprehensive" policy, dated June 1, 2000, revealed the comprehensive care plan was to be developed for each resident and was to include measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. A review of Resident #30's comprehensive care plan, initiated on 11/24/15, revealed the resident was at risk for nutritional problems. There was an updated problem statement, dated 04/04/19,	F 656	F656 Develop/Implement Comprehensive Care Plan #1 Resident #30 was assessed by Director of Nursing (DON) on 7/12/19 for any physical or emotional effects related to failure to implement the resident s care plan with no negative findings noted. #2 Residents that are currently on psychotropic medications and residents who receive dietary recommendations have the potential to be affected by the practice. All residents that are currently on psychotropic medications care plans were audited to ensure that all current GDRs have been added to the current plan of care and is accurate by the The Minimum Data Set (MDS) Registered Nurse (RN) on 7/29/19 with no concerns noted. Care plans for residents that have had dietary	

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F 656	Continued From page 2 which indicated there had been a five (5) percent (%) weight loss, due to poor appetite. There were interventions listed including the "Registered Dietician (RD) to evaluate and make diet change recommendations as needed (PRN)". Resident #30 also had a care plan, initiated 02/28/19, to address psychotropic medication. Interventions included to consult with pharmacy and the medical doctor (MD) to consider dosage reduction when clinically appropriate, but at least quarterly. A review of the Registered Dietician's (RD) note, dated 6/28/2019, revealed the resident had experienced a 30 day weight loss of 5.7%, a three (3) month weight loss of 11%, and a six (6) month weight loss of 16.7%; and weight maintenance was desired. Resident #30's current diet was a No Added Salt (NAS), heart healthy, mechanical soft diet with a bedtime (HS) snack. The RD filled out a form titled, "Consultant Dietician Communication to Director of Nursing (DON) and Nursing Staff", dated 06/28/19, with a RD recommendation for Boost Plus (supplement) twice a day (BID) for poor appetite. Review of the current physician's orders, revealed no orders for Boost twice daily and the resident was not observed to receive the Boost supplement. A review of a form titled, "Psychiatric Evaluation", for Resident #30, completed by the Psychiatric Nurse Practitioner (PNP) on 04/08/2019, revealed the PNP made a recommendation to, "Change Zyprexa to 2.5 mg PO BID". The Facility Nurse Practitioner (NP) signed the form and noted agreement on 04/13/2019. The NP handwrote an order on 04/13/19 that read, "Change Zyprexa to	F 656	recommendations in the past 30 days were audited by the MDS RN on 7/29/19 to ensure that all recommendations approved/ordered by the healthcare provider have been implemented on the current plan of care. #3 An in-service was initiated on 7/29/19 and will be completed by 8/2/19 by the Director of Nursing (DON) for LPNs and RNs regarding ensuring that the plan of care is being followed for each resident and is updated with any needed changes. Any changes regarding dietary recommendations and/or psychotropic medication changes will be reviewed to ensure that the changes have been implemented on the resident s current plan of care Monday Friday by the MDS RN, and the RN Supervisor on weekends. Any discrepancies found will be corrected at that time by the MDS RN or the RN Supervisor. #4 The MDS RN will audit all resident s care plans with any dietary recommendations received from the Registered Dietician (RD) to ensure that the care plan was implemented according to any new interventions/orders given per the Healthcare Provider weekly for six (6) weeks. The MDS RN will audit five (5) resident s care plans weekly for six (6) weeks to ensure that the care plan was implemented according to gradual dose reductions and/or psychotropic medication changes as ordered per the healthcare provider. Any found not to be correct will be corrected at that time by the MDS RN.	

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F 656	Continued From page 3 2.5 mg BID". Review of the current physician's orders and Medication Administration Record (MAR), for Resident #30, revealed Zyprexa 5 mg at Hour of Sleep (HS) and Zyprexa 2.5 mg BID were both ordered/administered. An interview on 07/11/19, at 11:15 AM, with Registered Nurse (RN) #2/ Care Plan Nurse, revealed she expected if the Registered Dietitian (RD) made a recommendation, that it would be followed. RN #2 stated the care plan should have included "Nursing to implement/follow dietary recommendations." RN #2 stated she normally puts that intervention on the care plan, but she just missed it on Resident #30's care plan. RN #2 stated the care plan was not followed if the Nurse Practitioner (NP) reduced the dosage, but the dosage was not reduced. RN #2 further stated she would normally write for nursing to implement/follow pharmacy, and/or MD recommendations and stated it should have been on the care plan. RN #2 stated the MD could be the attending physician or his designee, meaning the NP would be considered acting for the MD.	F 656	Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly and as needed for review, revision, and /or resolution to the plan.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		8/2/19

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F 692	Continued From page 4 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to implement the Registered Dietitian's (RD) recommendation for a dietary supplement consistent with the resident's assessed needs for one (1) of four (4) residents reviewed for nutrition, Resident #30. Findings include: A review of Resident #30's weight records revealed on 4/10/2019, the resident weighed 147.4 pounds (lbs) and on 7/10/2019, the resident weighed 129.6 lbs. This was a 12.08 percent (%) loss in a three (3) month period. A review of the Registered Dietician's (RD) note, dated 6/28/2019, revealed the resident had experienced a 30 day weight loss of 5.7%, a three (3) month weight loss of 11%, and a six (6) month weight loss of 16.7%; and weight maintenance was desired. Resident #30's current diet was a No Added Salt (NAS), heart healthy, mechanical soft diet with a bedtime (HS) snack. The RD filled out a form titled, "Consultant	F 692	F692 Nutrition/Hydration Status Maintenance #1 Resident #30 was assessed for any physical effects related to no order for supplement noted with no negative findings noted on 7/12/19 by Director of Nursing (DON). #2 All residents who receive dietary recommendations has the potential to be affected by this practice. All recommendations made by the Registered Dietician (RD) for the past 30 days were reviewed by Director of Nursing (DON) on 7/29/19 to ensure all recommendations were completed as recommended. No concerns were found with completion of the audit. #3 All dietary recommendations will be completed within 24 hours or the next business day of receipt from the RD by The Medical Records Nurse (MRN). An in-service was initiated on 7/29/19 and will	

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F 692	Continued From page 5 Dietician Communication to Director of Nursing (DON) and Nursing Staff", dated 06/28/19, with a RD recommendation for Boost Plus (supplement) twice a day (BID) for poor appetite. A review of the resident's physician's orders revealed there was no order for Boost Plus BID. Observations of Resident #30 in the dining room for the breakfast meal on 07/10/19 at 08:35 AM, and on 07/11/19 at approximately 08:00 AM, revealed no Boost on her tray or served to her. An interview with Licensed Practical Nurse (LPN) #2 at 8:50 AM, on 7/11/2019, revealed she received dietary recommendations from the Registered Dietician (RD) via electronic mail (e-mail) each week. LPN #2 stated the Nurse Practitioner (NP) or attending physician (MD), if resident is on Hospice, would be notified immediately of any recommendations of the RD by LPN #2 via phone or in person if they were in the facility. LPN #2 stated she would obtain any orders from the NP or MD regarding dietary supplements. LPN #2 stated she would enter any orders received in the computer and would place the RD recommendation in a folder to be signed off when the NP or MD next visited the facility. When asked if there was a dietary recommendation and order for Resident #30 from 06/28/2019, LPN #2 pulled a folder from her desk and found the recommendation dated 06/28/19. LPN #2 stated she had not obtained an order for the supplement recommended, because she knew the physician was scheduled to visit the facility on 07/11/19. LPN #2 stated the recommendation had been signed by the NP on 07/3/2019, but was awaiting the MD's signature because the resident was on hospice and orders	F 692	be completed on 8/2/19 by Director of Nursing (DON) for all LPN s and RN s in the facility regarding ensuring that all dietary recommendations are completed within 24 hours or the next business day of receipt from the RD by Medical Records Nurse (MRN). #4 The Director of Nurses (DON) will audit all dietary recommendations weekly for six (6) weeks beginning on 7/29/19 to ensure that all recommendations have been completed and within 24 hours or next business day. Any recommendations found to not be completed will be completed at that time by the DON. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly and as needed for review, revision, and/or resolution to the plan.	

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F 692	Continued From page 6 had to be obtained for hospice residents from the MD. LPN #2 stated, "I messed up, it was just Boost, I didn't think it was as important like a medication. I didn't think it needed to be handled immediately." An interview with the Dietary Manager at 11:20 AM, on 7/11/2019, revealed she had not received any recent orders for a supplement for Resident #30 from the NP or MD. She stated that once an order is obtained, she would add the order to the resident's tray ticket. The Dietary Manager stated when the RD makes a recommendation, it should be implemented as soon as possible, to maintain weight or prevent weight loss. An interview with the RD at 11:25 AM, on 7/11/2019, confirmed she had recommended a supplement for Resident #30 to address her weight loss on 6/28/19, about two (2) weeks ago. The RD stated she would expect dietary recommendations to be implemented "immediately/as soon as possible". An interview with the MD at 11:33 AM, on 7/11/2019, revealed that he would expect dietary recommendations to be implemented within a few days. The MD stated he would give an order when notified and stated, "They can call the hospice nurse/doctor or me, just not at 3:00 AM."	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		8/2/19

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F 758	Continued From page 7 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 8 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure that an antipsychotic medication was gradually reduced upon recommendation by the Nurse Practitioner and without documented contraindication for the reduction for one (1) of four (4) residents reviewed for psychotropic meds, Resident #30. Findings include: Review of the facility's "Psychotropic Medications" policy, with a revision date of 02/15/19, revealed: Residents admitted with psychotropic medications currently in use would be evaluated by the attending physician and pharmacy consultant to determine if the medication could be reduced or discontinued. If a gradual dose reduction was contraindicated the physician was to document the rationale in the clinical chart. Unsuccessful gradual dose reductions were to be documented in the clinical chart. Observations of Resident #30 at 10:30 AM on 07/09/19, at 8:35 AM on 07/10/19, and at approximately 8:00 AM and 10:45 AM on 07/11/19, revealed the resident to be pleasantly confused with no behaviors indicating any signs or symptoms of distress. A review of Resident #30's current physician's orders, for the month of July 2019, revealed orders for Zyprexa 5 milligram (mg)at bedtime (HS) for Mood with a start date of 04/02/19, and	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use #1 Resident #30 was assessed for any physical and/or psychological concerns on 7/12/19 by Director of Nursing (DON) with no concerns noted related to not having a Gradual Dose Reduction (GDR) completed. #2 Residents currently on psychotropic medications have the potential to be affected by this practice. All residents (17) that are currently on psychotropic medications charts were reviewed including orders and psychiatric evaluations to ensure that all recommended GDRs have been completed as recommended and/or ordered or documentation completed for any that were not ordered/changed. No concerns were noted upon completion of the audit. #3 All GDRs and psychiatric evaluations will be reviewed weekly during Persons At Risk (PAR) meeting to ensure all have been completed by Director of Nursing (DON). All order changes or new orders for psychotropic medications will be checked for accuracy by the Medical Records Nurse (MRN) Monday-Friday during clinical meeting and by the RN Supervisor on the weekends. An	

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F 758	Continued From page 9 Zyprexa 2.5 mg twice daily (BID) for mood related to Dementia in other diseases classified elsewhere, without behavioral disturbance, with a start date of 04/18/19. Further review of the physician's orders and nurse's notes revealed Resident #30 had returned to the facility from a geriatric psychiatric facility (geri-psych) stay on 04/02/19, with orders for Zyprexa 5 mg at HS for mood and Zyprexa 2.5 mg in the evening for mood. A review of a form titled, "Psychiatric Evaluation", completed by the Psychiatric Nurse Practitioner (PNP) on 04/08/2019, revealed the PNP made a recommendation to, "Change Zyprexa to 2.5 mg PO BID". The Facility Nurse Practitioner (NP) signed the form and noted agreement on 04/13/2019. The NP handwrote an order on 04/13/19 that read, "Change Zyprexa to 2.5 mg BID". A review of the Electronic Medical Record revealed the Facility NP order was entered into the system by Registered Nurse (RN) #1 on 04/13/2019, as Zyprexa 2.5 mg by mouth twice a day and scheduled for 7-10 AM (morning) and 7-10 PM (HS). The Zyprexa 5 mg order remained active in the system. On 4/18/2019, the scheduled time for the Zyprexa 2.5 mg was changed to 7-10 AM and 1-3 PM (evening) with the Zyprexa 5 mg dose still given at 7-10 PM (HS). The resident's daily dose of Zyprexa was increased from a total of 7.5 mg to 10 mg per day instead of being decreased to 5 mg a day as ordered. A review of an NP progress notes regarding Resident #30 revealed a note from the NP dated	F 758	in-service was initiated on 7/29/19 and will be completed by 8/2/19 by Director of Nursing (DON) for all LPN s and RN s related to ensuring all GDRs are followed per the Healthcare Provider s order and entered correctly. #4 The Director of Nurses (DON) will audit five (5) resident s charts weekly for six (6) weeks beginning on 7/29/19 to ensure that all GDRs have been completed and any current orders are accurate. Any charts found inaccurate will be corrected at that time by the DON. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly and as needed for review, revision, and/or resolution to the plan.	

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F 758	Continued From page 10	F 758		

04/13/19, stating, "Staff reports now that Zyprexa is causing her to sleep all day and all night. Denies her with any outward behaviors. Will attempt a GDR." The NP Progress Note dated 4/17/2019, included "She has exhibited no further outward behaviors. She has tolerated GDR of Zyprexa w/o (without) any problems" and "Continue Zyprexa 2.5 mg BID".

A review of a Patient At Risk (PAR) Note, dated 6/14/2019, revealed "On PAR r/t (related-to) anti-psychotic medication. PT (Patient) is on hospice. Last GDR (gradual dose reduction) was on 4/13/2019, which was before admission to hospice. No behaviors noted."

A review of Resident #30's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/24/2019, revealed the resident had no delusions or hallucinations, and had no behavioral symptoms directed toward others.

A review of the Medication Administration Record (MAR) revealed the resident had four (4) documented days when she exhibited behaviors since her return from the geri-psych stay approximately 100 days ago. The behaviors were documented as screaming and crying and delusion. None of these behaviors were documented to be a danger to the resident or others.

An interview with Licensed Practical Nurse (LPN) #1, on 7/10/2019 at 10:15 AM, revealed, "She hasn't had any behaviors since she returned from geri-psych."

An interview with Registered Nurse (RN) #1 on

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VAIDEN COMMUNITY LIVING CENTER	868 MULBERRY STREET VAIDEN, MS 39176

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F 758	Continued From page 11	F 758		

7/10/2019, at 10:26 AM, revealed the resident had become very confused and was striking out at staff and other residents and could not be re-directed prior to going to the geri-psych facility. RN #1 stated the resident still had confusion was now very easily re-directed.

A phone interview with RN #3 on 7/10/2019, at 1:57 PM, revealed she was not aware of any behaviors that would be considered a danger to the resident or others since her return from the geri-psych facility.

An interview with the Director of Nursing (DON) on 7/10/2019, at 5:00 PM, revealed Resident #30 had not exhibited any behaviors that were a threat to herself or others that he was aware of since her return from the geri-psych hospitalization.

A phone interview on 07/10/19, at 5:46 PM, with the facility NP revealed, "I agreed with the gradual dose reduction due to drowsiness reported by staff. I meant for the dose to be lowered to 2.5 mg twice a day." When asked if the Zyprexa 5 mg should have been discontinued, she said, "Yes". The NP stated she had not caught that the resident was still on the 5 mg tablet at bedtime. She stated she had stopped following the resident because she was admitted to hospice.

An interview with RN #1 on 07/11/2019, at 8:40 AM, revealed that the Nurse Practitioner/Physician writes orders and gives them to the charge nurse and the charge nurse enters the orders into the computer system. RN #1 stated she was the Charge Nurse who entered the order change on 04/14/19 for Resident #30. When asked about the order written by the Nurse

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F 758	Continued From page 12 Practitioner on 4/13/2019 to "Change Zyprexa to 2.5 mg BID", she stated, "I discontinued the Zyprexa 5 mg". RN #1 pulled up the current orders on the computer and agreed the Zyprexa 5 mg was still an active order. RN #1 stated, "It was a mistake, I thought I discontinued it." RN #1 further stated since she did not pass the medications, she had not noticed the order was still in place. An interview with Resident #30's attending physician on 07/11/19, at 11:33 AM, revealed he relies on the nurses at the facility to alert him to any problems with medications. He stated he felt not reducing the medication on Resident #30 was a medication error and he did not believe the medication was that dangerous for her to take. It was his opinion that there was not sufficient evidence that antipsychotic medication should be contraindicated for residents with dementia.	F 758		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to provide an effective pest control program to prevent flies observed in the dining room, resident rooms, and the kitchen for three (3) of three (3) days of survey. Findings include:	F 925	F925 Maintains Effective Pest Control Program #1 The pest control company was contacted on 7/9/2019 by the Facility Maintenance Director regarding flies in the facility. The pest control company visited the facility on 7/10/2019 and performed a routine visit as well as a treatment for flies. The facility received fly	8/2/19

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F 925	Continued From page 13 Record review of the facility's "Pest Control" policy, dated June 6, 2013, revealed the facility will have an effective pest control program. The facility will have a pest control contract that provides for frequent treatment of the environment for pests. It will allow for additional visits when a problem is detected. Monitoring of the environment will be done by the facility's staff. Pest control problems should be reported promptly to the contractor. On 7/9/2019, at 11:46 AM, an observation of residents dining in the small dining room revealed a fly on the table which was observed landing on a resident's tray, hand, and food. At the front table on the east side of the dining room an observation of three (3) flies which landed on resident's food, utensils, hands, arms, and drink glasses rims. An observation in the kitchen at a table to the right of the door were four (4) flies in the air and landing on the table. On 07/09/19 at 11:52 AM, an observation of Resident # 4 in his room, sitting on the edge of his bed feeding himself lunch, revealed a fly landing on his food, napkin, toast, edge of water cup, and on his tray, which had okra, chicken, rice, toast, fruit, tea, and water. On 7/10/19 at 10:13 AM, an observation revealed three (3) flies in the air around the nurse's station. On 07/11/19, at 11:26 AM, an observation while on tour with the Housekeeping Supervisor (HS), revealed flies on the 300 hall in room 311, 310, and in the hall around room 315. The HS revealed she had been spraying the only spray she could spray in the halls and in the resident's rooms that prevents flies. The spray being used	F 925	spray to use within the facility from the pest control company on 7/10/2019. #2 Residents in the facility have the potential to be affected by the practice. 100% facility rounds were performed by Administrator in Training (AIT) on 7/11/2019 to ensure that all areas were free of flies. Flies were noted around the dining room not during mealtime. Area was sprayed with a multi-pest elimination spray with improvement noted. #3 Pest control company will visit the facility twice monthly instead of monthly and as needed to ensure compliance with the pest control program. An in-service was initiated on 7/29/19 and will be completed by 8/2/19 for all facility staff by Administrator in Training (AIT) regarding notifying the Facility Administrator with any concerns about flies or other types of pests within the facility. All fly curtains in the facility were inspected by Facility Maintenance Director on 7/10/19 and found to be functioning correctly. On 7/29/19 Facility Maintenance Director preformed preventive maintenance on all fly curtains, and all found to be functioning correctly. #4 The Facility Administrator will interview two (2) residents three (3) times per week for six (6) weeks to ensure that no residents are having any complaints or concerns related to flies in the facility. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly	

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F 925	Continued From page 14 was (name of the pest eliminator) and she revealed she began using this spray on 7/10/19. On 07/10/19 at 10:13 AM, interviews during the group meeting, with five (5) residents, revealed all five (5) reported issues with flies. The residents revealed it had really been bad lately and that is why they have fly swatters in their rooms, so they can kill the flies. The residents revealed everyone knows there is a fly problem; the housekeepers keep a fly swatter on their cart to kill flies. On 07/11/19 at 10:45 AM, an interview with the Administrator (ADM) revealed he was not aware of a fly issue in the building and no one told him there were flies in the resident's rooms. The ADM revealed he is doing everything he can to prevent the flies and it is just how it is here; there is a cow pasture across the road. The ADM revealed he would not want to eat food that a fly had landed on. The ADM revealed the pest control company comes monthly, but they could come more often if needed. Review of the customer service receipts of (name of company) visits to the facility revealed treatments for flies one (1) time a month in April, May, June and July. No other receipts were provided.	F 925	and as needed for review, revision, and/or resolution to the plan.	

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	255283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 Chapter 10, and NFPA 101 section 9.6. The deficient practice affected all smoke compartments and all 50 residents in facility on the day of survey.	K 341	K341 Fire Alarm System- Installation #1 American Fire Safety contacted on 7/11/19 by Facility Maintenance Director regarding trouble signal 121 on the panel of the fire alarm system and the manual pull stations near the exit doors on the	8/2/19

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

Electronically Signed | 08/02/2019

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 341	Continued From page 1 Findings include: On July 11, 2019 at 10:10 AM observation also revealed a "trouble signal 121" on the panel of the fire alarm system. On July 11, 2019 at 10:45 AM, observation and testing revealed manual pull stations near the exit doors on the 100, 200, and 300 Halls of the facility did not activate the fire alarm system. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 7/11/19.	K 341	100, 200, and 300 halls of the facility not activating the fire alarm system. American Fire Safety visited the building on 7/11/19 at approximately 2:30pm and replaced smoke detector head and base in room # 302 that was the cause of the short in the facility fire alarm panel. #2 All residents in the facility have the potential to be affected by the practice. At approximately 10:15am on 7/11/19 a manual fire watch was initiated by the Facility Maintenance Director with no negative outcomes noted. #3 An in-service was initiated on 7/29/19 and will be completed by 8/2/19 for all facility staff by Facility Maintenance Director regarding notifying the Facility Maintenance Director with any concerns regarding warning lights on fire panel. On 7/18/2019 American Fire Safety completed Annual Fire Alarm Inspection and Testing with no noted concerns. #4 The Facility Maintenance Director will audit fire panel and pull stations on 100, 200, and 300 hall two (2) times a week for six (6) weeks beginning 7/29/19 to ensure that fire panel and pull station are functioning properly. Any trouble signal or complication with fire panel or pull stations will immediately be reported to Administrator and American Fire Safety and a fire watch will be implemented immediately. Findings will be reported to Quality Assurance Committee (QAPI) monthly and as needed for review, revision, and/or resolution to plan.	

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E 000	Initial Comments EMERGENCY PREPAREDNESS Survey conducted on 07/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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