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	255306	A. BUILDING _____ B. WING _____	12/17/2019

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 12/15/19 to 12/17/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited deficient practice at F550, F757, F825, F921 and F947. The census at the time of the survey was 64, with a bed capacity of 66.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		1/6/20

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

Electronically Signed | 01/03/2020

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to preserve the resident's dignity as evidenced by failure to transport the resident to the shower with proper coverage for one (1) of 16 sampled residents, Resident #11. Findings include: Review of the facility's "Promoting/Maintaining Resident Dignity" policy, undated, revealed: It is the practice of this facility to protect and promote resident's rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances the resident's quality of life by recognizing each resident's individuality. The compliance guidelines reveal all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.	F 550	This Plan of Correction is being submitted in response to alleged deficiencies. The submission of this Plan of Correction is not an acknowledgement of the accuracy of these alleged deficiencies. On December 16, the Certified Nurses Aide (CNA) Supervisor provided one-on-one training to CNA #4 on resident dignity, related to moving residents though the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. Resident #11 was dressed, with any bare skin covered, after the completion of the shower on December 16. Resident #11 was fully covered while being transported from the shower room on December 16. Resident #11 will have any bare skin covered by a sheet or blanket while being	

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F 550	Continued From page 2 An observation, on 12/16/19 at 8:45 AM, revealed Certified Nursing Assistant (CNA) #4 pushing Resident #11 in a wheelchair in the hallway. The resident had on a short top that covered only the upper one fourth of her thighs. Resident #11's feet were bare and she was holding a brief in her hands. CNA #4 pushed the resident to the linen cart and retrieved a sheet to cover her. An interview, on 12/16/19 at 8:46 AM, with Licensed Practical Nurse (LPN) #2, revealed she saw Resident #11 being pushed in the hallway exposed. LPN #2 stated that was why she made a shocked face when she saw it. LPN #2 stated she told CNA #4 the resident should be covered. LPN #2 stated Resident #11 could have been seen by a visitor, another resident, or someone of the opposite sex. An interview, on 12/16/19 at 10:30 AM, with CNA #4, confirmed she pushed Resident #11 in a wheelchair down the hallway to the linen cart. She stated the resident was coming out of her room and all she thought was to go to the linen cart and get a sheet. She confirmed she did not think to keep the resident in her room and ask for assistance from staff in the hallway. An interview, on 12/16/19 at 10:45 AM, with Registered Nurse (RN) #1, confirmed residents should not be brought into the hallway exposed. RN #1 stated that was a dignity issue. An interview, on 12/17/19 at 10:15 AM, with the Director of Nursing (DON), revealed she felt CNA #4 got nervous and did not do what she should have. The DON stated this was a dignity issue and CNA #4 should have had Resident #11 covered, before allowing her to be in the hallway.	F 550	moved through the hall to or from the shower room. Any resident has the potential to be affected by this allegedly deficient practice. On December 30 the Certified Nurses□ Aide (CNA) Supervisor reeducated CNA #4 on resident dignity, related to moving residents though the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. On December 30 the CNA Supervisor educated the other Shower Aide on resident dignity, related to moving resident through the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. On December 30, December 31, January 2, and January 3, the CNA Supervisor will educate the CNAs on duty on resident dignity, related to moving residents through the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. Beginning January 6, this dignity education will be included in new employee orientation. This education will include the requirement that residents must be covered while being transported to and from the shower room. Beginning January 6, the CNA Supervisor will monitor staff moving residents through the hall to and from the shower room daily, Monday through Friday, for two	

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F 550	Continued From page 3 She stated Resident #11 should have had socks on her feet and a sheet or blanket covering her lower body.	F 550	weeks. Beginning January 6, the CNA Supervisor will interview three residents per shower day, Monday through Friday, for two weeks, then by then two residents a days for two weeks, and one resident a day for two weeks. The CNA Supervisor will report the findings of these resident interviews to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		1/6/20

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F 757	Continued From page 4 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident was free of unnecessary medications, as evidenced by failure to discontinue Ativan as ordered by the Physician, Resident #33; for one (1) of six (6) residents reviewed for unnecessary medications. Findings Include: Review of the facility's "Use Of Psychotropic Drugs" policy, undated, noted residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Review of the physician's handwritten order, dated 11/29/19, revealed an order to discontinue Ativan 0.5 milligrams (mg) by mouth (po) due to refusal of medication. Further review of the November 2019 Medication Administration Record (MAR), revealed Ativan 0.5 mg was received on 11/30/19. A review of the December 2019 MAR, revealed Resident #33 received Ativan 0.5 mg for nine (9) days between 12/1/19 and 12/16/19. Ativan was documented on 12/4, 12/5, 12/7-12/11, 12/13 and 12/14/19. Interview on 12/17/19 at 4:46 PM, with the Director of Nursing (DON), revealed when an	F 757	On December 17, the Director of Nursing (DON) faxed to the hospital and local pharmacies, the order to discontinue the use of Ativan 0.5mg by Resident #33. The Registered Nurse (RN) Supervisor discontinued the order for Ativan 0.5mg in the electronic medical record. The DON and RN Supervisor removed the cards of Ativan 0.5mg for Resident #33 from the Medication Cart. On December 17, the DON and RN Supervisor assessed Resident #33 for adverse side effects attributed to Ativan, with none apparent. Any resident has the potential to be affected by this alleged deficient practice. On December 30, December 31, January 2, and January 3, the DON will educate the Licensed Practical Nurses (LPNs) and RNs on duty to fax any order to discontinue the use of a medication to the hospital and local pharmacies. After January 4, an order to discontinue the use of a medication will be faxed to the hospital and local pharmacy. Beginning January 6, the DON will reconcile orders to discontinue medications with faxes received by the hospital pharmacy daily, Monday through Friday, for two weeks, then three days a week for two weeks, and two days a week for two weeks. The DON will report on this reconciliation	

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F 757	Continued From page 5 order is handwritten on the resident's chart, the order should be faxed to the hospital pharmacy and the local pharmacy. The DON stated the facility failed to fax the handwritten order to the pharmacy, therefore, the medication administration was continued in error.	F 757	process to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and policy review, the facility failed to provide Rehabilitation services to a resident who had orders for Restorative Nursing, for one (1) of one (1) residents reviewed with orders for rehab services, Resident #21.	F 825	On December 12, the Restorative Nursing Coordinator (RNC) evaluated Resident #21 for the restorative nursing program. On December 16, Resident #21 began the restorative nursing program.	1/6/20

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F 825	Continued From page 6 Findings include: Review of the facility's, "Restorative Nursing Programs" policy, dated 5/15/19, revealed: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. On 12/15/19 at 10:22 AM, an interview with Resident #21, revealed her therapy ended about two (2) weeks ago, and was told she would get started with Restorative therapy, but has not at this point. Resident #21 stated she didn't want to lose the progress she had gained thus far. Review of the Physician's orders, dated 11/26/19, revealed Occupational Therapy (OT) discharged Resident #21 on 11/26/19, with an order for the resident to receive Restorative Nursing six (6) to seven (7) times weekly, in order to maintain progress achieved throughout intervention. On 12/17/19 at 8:48 AM, an interview with Registered Nurse (RN) #1, revealed the resident was discharged from therapy on 11/26/19, and Restorative Nursing should have started at that time, but did not. RN #1 stated the facility failed to note the order off, and Restorative Nursing was not started. RN #1 stated chart check is performed nightly, but the order was missed during chart check also. On 12/17/19 at 9:11 AM, an interview with the Occupational Therapist revealed she discharged Resident #21 on 11/26/19, and gave the Restorative Nurse a copy of the treatment plan on that date. She stated she would have expected	F 825	Any resident with a potential need for inclusion in the restorative nursing program has the potential to be affected by this alleged deficient practice. Resident #21 began the restorative nursing program on December 16. Beginning January 6, a resident discharging from therapy services that has a continued need for rehabilitation and will remain a resident of the facility will be discharged with a plan for restorative nursing. The Physical Therapist, Occupational Therapist, or Speech Therapist will develop this plan prior to discharge. Beginning January 6, the Director of Therapy (DOT) will report to the Director of Nursing (DON) any resident discharging from therapy with a recommendation for continuation of services through the restorative nursing program weekly for four weeks, then every other week for four weeks, and monthly for one month. Beginning January 6, the RNC will report any new or changing restorative nursing programs to the DON weekly for four weeks, then every other week for four weeks, and monthly for one month. The DON will report on these therapy discharges and new or changing restorative plans to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance	

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F 825	Continued From page 7 therapy to start within 24-48 hours. On 12/17/19 at 9:14 AM, an interview with Licensed Practical Nurse (LPN)/Restorative Nurse, revealed she received the treatment plan for Restorative Nursing from the Occupational Therapist on 11/26/19. LPN #3 confirmed therapy was not initiated timely. The Restorative Nurse stated she spoke with the resident yesterday, and plans to get therapy started today. On 12/17/19 at 9:53 AM, an interview with the Director of Nursing (DON), revealed Restorative should have been initiated within 72 hrs of orders being written by therapy.	F 825	improvement plans as necessary to ensure ongoing compliance.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, policy review, and preventative maintenance documentation review, the facility failed to ensure a clean and safe environment, as evidenced by dust and lint buildup on wiring to heating and cooling units, for 42 of 50 resident rooms, and oxygen cylinder tanks in resident rooms not properly secured, for two (2) of 18 residents receiving oxygen therapy, Resident #56 and #19. Findings include: Review of the facility's "Therapeutic Gases"	F 921	On December 16, the Director of Nursing removed and secured the hospice-provided oxygen tanks from the rooms of Residents #19 and #56. On December 17, a 6-tank storage rack was ordered. The rack arrived and placed in a Medication Room on December 18. Oxygen tanks supplied by hospice providers will be stored in this rack. On December 16, Maintenance Employee (ME) #1 began cleaning the in-room blower units throughout the facility. ME #1 completed this task on December 19.	1/6/20

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F 921	Continued From page 8 policy, dated 11/14/18, revealed: Oxygen tanks are to be stored in a designated area and the areas are labeled as partial, full, or empty. Oxygen tanks are transported by a secured rolling cart. On 12/16/19 at 2:30 PM, an observation of the enclosed heating and cooling unit, with the Administrator in room 447, revealed the wiring leading to the thermostat was covered in a thick coating of dust and lint. The Administrator stated he felt this could be a fire hazard and was in need of cleaning. The Administrator stated the hospital maintenance staff was responsible for the preventative maintenance of heating and cooling units. He stated he was not sure when they had been cleaned, but it was obvious it had been quite a while. On 12/17/19 at 10:30 AM, an environmental tour, with Maintenance Employee #1, revealed 42 of the 50 rooms in the facility had dust and lint build up on the wires leading to the thermostat. Maintenance Employee #1 stated quarterly preventative maintenance was performed on the heating and cooling units, and vacuuming and cleaning the unit's housing was a part of the preventative maintenance. Maintenance Employee #1 stated he did not know when they were last cleaned. He stated the employee who most often takes care of the nursing home has been off on medical leave. Maintenance Employee #1 confirmed the units were in need of cleaning. He stated they have a wet/dry vacuum they use to vacuum the dust and lint particles. Review of the quarterly maintenance records, with Maintenance Employee #1, did not indicate the heating and cooling units had been cleaned.	F 921	Any resident requiring oxygen and on hospice has the potential to be affected by this alleged deficient practice. Any resident using an in-room blower unit has the potential to be affected by this alleged deficient practice. Beginning December 19, oxygen tanks supplied by hospice providers will be stored in the 6-tank storage rack placed in a Medication Room. Beginning December 30, the Administrator will observe for proper storage of oxygen tanks daily, Monday through Friday, for two weeks, then three days a week for two weeks, and two days a week for two weeks. Beginning December 30, hospice providers will store oxygen cylinders in this storage rack. As of December 23, cleaning the wiring and open spaces in the in-room blower units has been added to the preventive maintenance schedule. Beginning December 30, the Administrator will insure cleanliness by inspecting four units a day, Monday through Friday, for two weeks, then two units a day for two weeks, and one unit a day for two weeks. Beginning December 30, the Maintenance Department will clean the wiring and open spaces in the in-room blower units as a part of the quarterly preventive maintenance schedule. The Administrator will report on these observations and inspections to the Quality Assurance Committee monthly for	

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F 921	Continued From page 9 Resident #19 An observation, on 12/15/19 at 10:49 AM, revealed an "E" oxygen cylinder laying on its side against the wall inside Resident #19's room. The oxygen cylinder was not secured. An observation and interview with Registered Nurse (RN) #1, on 12/16/19 at 8:50 AM, revealed the oxygen cylinder remained on the floor in Resident #19's room, unsecured. RN #1 determined the oxygen cylinder tank was full. She stated the tanks were brought in by hospice and needed to be secured, because the tank could blow up. An interview, on 12/16/19 at 9:05 AM, with the Director of Respiratory Therapy (DRT), revealed the oxygen tanks were brought in by hospice, but they should be secured. The DRT confirmed the oxygen tank was full cylinder of oxygen and should have been secured in a container. She stated the Respiratory Therapy staff is responsible for, and monitors all oxygen in the facility. She stated they make rounds twice a day and should have noticed the cylinder laying on the floor. She stated the cylinder could have gotten moved or bumped and busted. An interview, on 12/17/19 at 10:10 AM, with the Director of Nursing (DON), confirmed oxygen cylinders should be secured. The DON stated the cylinder could roll, causing a tripping or fall risk, and is combustible. Resident #56 An observation of Resident #56's room, on 12/15/19 at 10:30 AM, revealed two (2) oxygen E-cylinder canisters at bedside. One (1) canister was noted in the canister holder, and the other	F 921	three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	

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F 921	Continued From page 10 canister was lying on the floor by the canister holder. During an observation on 12/16/19 at 2:15 PM, the oxygen canister remained on the floor. At that time, the Respiratory Therapist (RT) came into Resident #56's room. The RT stated Hospice left an extra E-cylinder in resident's room, in case it was needed. The RT stated she recognized the danger in leaving an oxygen cylinder lying on the floor. She stated it could be a fall hazard and since it is compressed gas, it could be dangerous if dropped. The RT stated the E-cylinder should be stored in a secure location. The RT took the extra cylinder tank from the resident's room.	F 921		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also	F 947		1/6/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 11 address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, the facility failed to provide staff education, related to Dementia care, for 40 of 40 Certified Nursing Assistants (CNAs) providing care to residents. Findings include: Review of the facility's "Care of Residents with Dementia" policy, dated 6/20/19, revealed: It is the policy of this facility for staff to be trained on dementia care of the resident. Approaches will be in accordance with dementia care principles. On 12/16/19 at 3:00 PM, an interview with the Administrator, revealed the last Dementia training was done in 3/2018. The Administrator stated dementia training is not done upon hire or routinely. He stated hospice staff has done some training related specifically to their residents, but doesn't recall any in-services directly related to dementia care. The Administrator stated the Hand in Hand videos needed to be implemented. Review of an in-service log, dated 3/2018, revealed the last dementia care in-service provided by the facility. On 12/17/19 at 7:16 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed she received dementia training last year, but can't recall exactly when. CNA #1 stated when a resident is admitted, they are given report and told if the resident has any behaviors. On 12/17/19 at 7:28 AM, an interview with CNA	F 947	On December 17, the facility arranged for dementia training for all staff on duty. This training was completed by those staff on duty on December 18. On January 3, the facility will begin dementia training utilizing the hand-in-hand training videos. Any resident has the potential to be affected by this alleged deficient practice. On January 3, the facility will begin dementia training with existing employees, utilizing the hand-in-hand training videos. Training will continue weekly until all modules are completed. Staff failing to attend will not be allowed to work until modules are caught up. New employees will be trained as a part of orientation prior to the first shift of independent work. The Administrator will report on attendance at these training sessions, the number of employees suspended due to lack of attendance, and any new employees beginning, within, or completing the training to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	12/17/2019

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FLOY DYER NH	1000 EAST MADISON HOUSTON, MS 38851

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F 947	Continued From page 12 #2, revealed she was hired September 2019, and had not received any training related to dementia care. CNA #2 stated she had been trained in the past, to allow the resident time to calm down before trying to provide care. On 12/17/19 at 8:02 AM, an interview with CNA #3, revealed she was hired in April 2019, and has not had any training related to dementia care. On 12/17/19 at 9:53 AM, an interview with the Director of Nursing (DON) confirmed the facility provided care to residents with dementia. The DON stated she started here September 30, 2019, and is responsible for training, related to dementia. The DON stated she feels training needs to be done upon hire and at least annually, or as needed, throughout the year. On 12/17/19 at 2:30 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed it has been a year or so since she attended in-service training on dementia. She stated the CNAs will come to her when a resident is combative or demonstrating behaviors. On 12/17/19 at 2:54 PM, an interview with LPN #2, revealed she last received training on dementia care greater than a year ago.	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2019**

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FLOY DYER NH	**1000 EAST MADISON** **HOUSTON, MS 38851**

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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 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly arrange exit discharge in accordance to NFPA 101 sections 19.2.7 & 7.7.1. These deficiencies practice affected one (1) of four (4) exits in the facility. Findings include: On 12-19-19 at 11:05 AM, observation revealed all the four (4) exit doors in the facility re-engage to lock position when the fire alarm system was put into silence mode. This locked mode of all the exit doors obstructed/ blocked the exit discharge from mean of egress in the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview	K 271	This Plan of Correction is being submitted in response to alleged deficiencies. The submission of this Plan of Correction is not an acknowledgement of the accuracy of these alleged deficiencies. On December 19, the Maintenance Director completed a temporary troubleshoot of the alarm and egress door magnets. Any resident has the potential to be affected by this alleged deficient practice. On January 3, Maintenance Department employees completed a repair of the alarm and egress door magnets.	1/6/20

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

Electronically Signed | 01/06/2020

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
	255306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2019**

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K 271	Continued From page 1 on 12-19-19.	K 271	The Maintenance Director will perform a test of each egress points 3 times a week for 2 weeks, then 2 times a week for weeks, and once a week for 2 weeks. The Administrator will report to the QA Committee monthly for 3 months.	

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E 000	Initial Comments ********** Survey conducted on 12/19/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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