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	255314	A. BUILDING _____ B. WING _____	01/09/2020

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey from 1/6/2020 to 1/9/2020. 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 F641, F656, F657, and F695. At the time of the survey, the census was 55, and the facility held a license for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one (1) of 19 MDS assessments reviewed, Resident #42. Findings include: Review of the facility's "Resident MDS Assessment" policy, revised 09/19, revealed: Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed. Review of Resident #42's Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 12/13/19, revealed Section N	F 641	1. Resident #42 Minimum Data Set assessment was modified to reflect no anticoagulant on 1/8/2020 by the Director of Nursing. Resident #42 was assessed by the Director of Nursing for adverse reactions on 1/9/2020 with no adverse reactions noted. 2. Seven (7) of (55) residents currently on Plavix were identified by the Director of Nursing to have the potential to be affected by this deficient practice on 1/8/2020. Seven (7) of 55 residents currently on Plavix were assessed by the Director of Nursing, Treatment Nurse, Nurse Case Manager, Assessment Nurse, Staff Development Nurse and/or Medical Records Nurse for adverse reactions on 1/9/2020 with no adverse	1/31/20

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

Electronically Signed | 01/31/2020

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.

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F 641	Continued From page 1 (Medications), Item N0410E, was answered to indicate the resident had received an anticoagulant medication for seven (7) days, during the look back period. Review of Resident #42's Medication Administration Record (MAR), dated December 2019, revealed no anticoagulant medications were administered, during the seven (7) day look back period. During an interview, on 01/08/20, at 12:02 PM, the Director of Nursing (DON) stated Resident #42 did not receive an anticoagulant medication. The DON stated Plavix, which is an antiplatelet, was mistakenly coded as an anticoagulant, and that made the MDS inaccurate.	F 641	reactions noted. 3. An in service was conducted on 1/30/2020 by the Quality Improvement Nurse on the policy/procedure titled MDS Charting Documentation Guidelines revised 9/19, which included coding of medications on the minimum data set per pharmacological classification which includes Plavix not being coded as an anticoagulant, with the Director of Nursing, Staff Development Nurse, Nurse Case Manager, Assessment Nurse, Treatment Nurse and Medical Records Nurse. The Quality Assurance Committee which includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, Assessment Nurse, Nurse Case Manager and Medical Records, reviewed the policy on MDS Charting Documentation Guidelines with revision date of 9/19 and did not recommend any changes on 1/30/2020. 4. Beginning 2/3/2020, the Director of Nursing and Nurse Case Manager will conduct weekly monitoring of Minimum Data Set assessments prior to submission to ensure that anticoagulants are correctly coded weekly for four weeks and monthly for two months and findings recorded on the utilization review meeting worksheet and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns from the rounds and evaluate the monitoring completed by the Director of Nursing and Nurse Case Manager monthly for three months and make any recommendations or changes	

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F 641	Continued From page 2	F 641	needed.	
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 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	F 656		1/31/20

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F 656	Continued From page 3 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, interview, record review, and facility policy review, the facility failed to implement the care plan related to storage of oxygen equipment, for two (2) of 19 resident care plans reviewed, Resident #2 and #39. Findings include: Review of the facility's "Care Plan Process" policy, revised 08/17, revealed: The comprehensive care plan is an interdisciplinary communication tool. The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The facility staff shall follow the care plan. Resident #2 Review of Resident #2's care plan, revealed a problem to address oxygen therapy related to shortness of breath (SOB), with an onset date of 06/10/19. Interventions included to change oxygen (O2) tubing and nasal cannula/mask weekly on Wednesday and flag with date and initials. Store in plastic bag, when not in use, with residents name and date. During an observation, on 01/06/20 at 11:30 AM, Resident #2's oxygen concentrator had a cannula	F 656	1. Oxygen tubing for Resident # 2 and Resident # 39 was changed on 1/2/2020 by Director of Nursing. Resident # 2 and Resident # 39 were assessed for signs and symptoms of infection on 1/9/2020 by the Nurse Case Manager/Licensed Practical Nurse and no signs and symptoms of respiratory infection were present. Resident # 2 and Resident # 39 oxygen care plans were reviewed by the Director of Nursing with no changes made on 1/9/2020. 2. Twenty (20) of (55) residents were identified as having oxygen orders by the Director of Nursing to have the potential to be affected by this deficient practice on 1/9/2020. Twenty (20) of twenty (20) residents were assessed by the Director of Nursing and Nurse Case Manager for signs and symptoms of respiratory infection on 1/9/2020 with no signs and symptoms identified. Twenty (20) of twenty residents oxygen care plans were reviewed for proper oxygen storage and changing of oxygen tubing with no deficits identified. 3. An in-service was conducted on 1/8/2020 by the Director of Nursing and Nurse Case Manager on the	

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F 656	Continued From page 4 cover bag laying on it, dated 12/25/19. There was no nasal cannula attached to the concentrator. During an observation, on 01/06/20 at 4:32 PM, Resident #2's oxygen concentrator was observed with a cannula cover bag laying on it, with a date of 12/25/19. There was no nasal cannula attached to the concentrator. During an observation and interview, on 01/07/20 at 8:30 AM, Resident #2's nasal cannula was observed to be laying across the resident's bed, uncovered, and dated 12/25/19. The cannula cover bag was dated 12/25/19. The Director of Nursing (DON) was brought to Resident #2's room to observe the placement of the cannula, and the dates on the cannula and cover bag. The DON confirmed they were both dated 12/25/19. The DON stated the oxygen tubing was to be changed one time a week, and should have been changed on 01/01/20. Resident #39 An observation, on 01/06/20 at 12:42 PM, revealed Resident #39's oxygen concentrator was turned on and running at 2 liters per minute (LPM). The nasal cannula and tubing was draped over the head of the bed, uncovered, and touching the floor behind the bed, and dated for 01/01/20. During an observation, on 01/06/20 at 3:30 PM, Resident #39's concentrator was turned on and running at 2 LPM. The nasal cannula, dated 01/01/20, was uncovered, draped over the head of the bed. and lying on the floor, behind the head of the bed.	F 656	policy/procedures titled Care Plan Process revised 8/17 which includes following care plan related to oxygen storage and changing of oxygen tubing, with Licensed Practical Nurses and Registered Nurses and continued until all nurses were in-serviced. The Quality Assurance Committee reviewed the policy on Care Plan Process with revision date of 8/17 on 1/30/2020 and did not recommend any changes. 4. Beginning 1/13/2020, rounds will be conducted by Director of Nursing and Nurse Case Manager residents to ensure compliance related to storage and changing of oxygen tubing weekly for four weeks and monthly for two months and findings recorded on rounds flow record and maintained by the Director of Nursing. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, Medical Records and Assessment Nurse, will address concerns identified from rounds and evaluate the monitoring completed by the Director of Nursing and Nurse Case Manager monthly for three months and make any recommendations or changes needed.	

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F 656	Continued From page 5 On 01/07/20 at 8:30 AM, Resident #39 was observed in bed, with a nasal cannula on, and dated 01/01/20. During an observation and interview, on 01/07/20 at 8:33 AM, the DON was informed of the observations made on 01/06/20, where Resident #39's nasal cannula was uncovered, draped over the head of the bed, touching the floor and dated 01/01/20. Resident #39 was wearing the same cannula when observed by the DON. The DON stated she would replace the nasal cannula. Review of Resident #39's care plan, revealed a problem for occasional shortness of breath (SOB)/wheezing, with an onset date of 01/25/18.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		1/31/20

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F 657	Continued From page 6 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview, and facility policy review, the facility failed to revise the care plan related to Nutrition for Resident #27 for one (1) of 19 resident care plans reviewed. Findings include: Review of the facility's "Care Plan Process" policy, dated 08/17, revealed: The comprehensive care plan is an interdisciplinary communication tool. The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the residents's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged, and must be consistent with each resident's written plan of care. Review of Resident #27's Care Plan, revealed a problem to address Nutritional Approaches Therapeutic diet: Carbohydrate Controlled Diet/Limited Concentrated Sweets (CCD/LCS), onset date of 11/26/19, and Goal and Target date, to follow therapeutic diet by 03/17/20. Interventions included to provide diet as ordered.	F 657	1. On 1/8/2020, the nutrition care plan for Resident #27 was revised to reflect the most recent physician order related to nutrition by the Assessment Nurse. One on one in-service was conducted with the Dietary Manager on 1/31/2020 by the Director of Nursing on policy titled Care Plan Process with revision date 8/17 to include ensuring nutrition accuracy for residents requiring nutrition via gastrostomy tube on the nutrition care plan. 2. Ten (10) of (55) residents were identified to be at risk for this deficient practice on 1/8/2020, related to requiring nutrition via gastrostomy tube by the Director of Nursing. On 1/8/2020, a care plan audit was conducted by the Director of Nursing and Nurse Case Manager on the ten (10) residents identified to have the potential to be affected by this deficient practice with no additional deficits identified. 3. An in-service was conducted on 1/8/2020 by the Director of Nursing on the policy/procedure titled Care Plan Process revised 8/17, which included ensuring	

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F 657	Continued From page 7 A review of Resident #27's "Physician Orders List", revealed an order, dated 06/19/19, to discontinue CCD/LCS diet. An order for Nothing by mouth (NPO), was initiated on 11/26/19. Resident #27 has a current order, dated 01/08/20, for Diabetasource AC tube feeding via Percutaneous Gastrostomy (PEG) Tube at 55 cubic centimeters (cc) per hour for 22 hours. Observations on 01/06/20 - 01/09/20 (dates of survey), revealed Resident #27 had a PEG tube in place, with Diabetasource AC infusing at 55 cc per hour. No meal tray was observed in the resident's room at any time. During an interview, on 01/08/20 at 12:10 PM, the Director of Nursing (DON) revealed the Dietary Supervisor completes the initial Nutrition care plan. The DON stated, "If this care plan was followed, something bad could happen." During an interview, with the Dietary Manager (DM), on 01/08/20 at 2:20 PM, she stated "It (care plan) should have been updated. I haven't had time." The DM stated, "I must have missed it" in reference to initiation of care plan upon admission. Review of the "Face Sheet", revealed, Resident #27 was admitted by the facility, on 11/26/2019, with diagnoses of Hemiplegia, Dysphagia, Gastrostomy Status, and Type 2 Diabetes Mellitus.	F 657	nutrition care plans are accurate for residents that require nutrition via gastrostomy tube, with Dietary Manager, Assessment Nurse and Nurse Case Manager, The Quality Assurance Committee reviewed the policy on Care Plan Process with revision date of 8/17 on 1/30/2020 and did not recommend any changes. 4. Beginning 1/13/2020, care plan audits on all new admissions and current residents that require nutrition via gastrostomy tube, will be conducted by the Director of Nursing and Nurse Case Manager to ensure compliance related to nutrition orders, weekly for four weeks and monthly for two months with findings recorded on rounds flow record and maintained by the Director of Nursing. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, Medical Records and Assessment Nurse, will address concerns identified from audits and evaluate the monitoring completed by the Director of Nursing and Nurse Case Manager monthly for three months and make any recommendations or changes needed.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		1/31/20

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F 695	Continued From page 8 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store oxygen equipment in a manner to prevent cross contamination for two (2) of 20 residents receiving oxygen therapy, Residents #2 and #39. Findings include: A review of the facility's "Infection Control Oxygen Equipment Cleaning" policy, revised 03/18, revealed: Tubing should be replaced every seven (7) days. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. Resident #2 During an observation, on 01/06/20 at 11:30 AM, Resident #2's oxygen concentrator had a cannula bag on it, dated 12/25/19. There was no nasal cannula attached to the concentrator. During an observation, on 01/06/20 at 4:32 PM, Resident #2's oxygen concentrator was observed with a cannula bag on it dated 12/25/19. There was no nasal cannula attached to the concentrator. During an observation and interview, on 01/07/20 at 8:30 AM, Resident #2's nasal cannula was	F 695	1. Oxygen tubing for Resident # 2 and Resident # 39 was changed on 1/2/2020 by Director of Nursing. Resident # 2 and Resident # 39 were assessed for signs and symptoms of infection on 1/9/2020 by the Nurse Case Manager/Licensed Practical Nurse and no signs and symptoms of respiratory infection were present. 2. Twenty (20) of (55) residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice on 1/9/2020. Twenty (20) of twenty (20) residents were assessed by the Director of Nursing, Treatment Nurse, Nurse Case Manager, Assessment Nurse, and/or Staff Development Nurse for signs and symptoms of respiratory infection on 1/9/2020 with no signs and symptoms identified. 3. An in-service was conducted on 1/8/2020 by the Director of Nursing and Nurse Case Manager on the policy/procedure titled Infection Control Oxygen Equipment Cleaning revised 3/18, which includes storage and changing of	

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F 695	Continued From page 9 observed to be laying across the resident's bed, uncovered, and dated 12/25/19. The cannula cover bag was dated 12/25/19. The Director of Nursing (DON) was brought to Resident #2's room to observe the placement of the cannula and the dates on the cannula and cover bag. The DON confirmed they were both dated 12/25/19. The DON stated the oxygen tubing was to be changed one time a week and should have been changed on 01/01/20. Review of Resident #2's care plan revealed a problem, with an onset date of 06/10/19, to address the resident receives oxygen therapy as ordered for shortness of breath (SOB) with exertion and sitting at rest. Interventions included to "Change O2 (oxygen) tubing and nasal cannula/mask weekly on Wednesday. Flag with date and initials. Store in plastic bag when not in use with residents name and date." Resident #39 An observation, on 01/06/20 at 12:42 PM, revealed Resident #39's oxygen concentrator was turned on and running at 2 liters per minute (LPM), with the nasal cannula and tubing draped over the head of the bed, uncovered and touching the floor, and dated for 01/01/20. During an observation, on 01/06/20 at 3:30 PM, Resident #39's concentrator was turned on and running at 2 LPM. The nasal cannula, dated 01/01/20, was uncovered, draped over the head of the bed. and lying on the floor, behind the head of the bed. On 01/07/20 at 8:30 AM, Resident #39 was observed in bed, with a nasal cannula on, and dated 01/01/20.	F 695	oxygen tubing, with Licensed Practical Nurses and Registered Nurses and continued until all nurses were in serviced. The Quality Assurance Committee reviewed the policy on Infection Control Oxygen Equipment Cleaning with revision date of 3/18 on 1/30/2020 and did not recommend any changes. 4. Beginning 1/13/2020, weekly rounds will be conducted by Director of Nursing and Nurse Case Manager to ensure compliance related to storage and changing of oxygen tubing weekly for four weeks and monthly for two months and findings recorded on rounds flow record and maintained by the Director of Nursing. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, Medical Records and Assessment Nurse, will address concerns identified from rounds and evaluate the monitoring completed by the Director of Nursing and Nurse Case Manager, monthly for three months and make any recommendations or changes needed.	

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F 695	Continued From page 10 During an observation and interview, on 01/07/20 at 8:33 AM, the DON was informed, by the surveyor, of the observations made on 01/06/20, where Resident #39's nasal cannula was uncovered, draped over the head of the bed, touching the floor and dated 01/01/20. Resident #39 was wearing the same cannula when observed by the DON. The DON stated she would replace the nasal cannula.	F 695		

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	255314	A. BUILDING **01 - WASHINGTON CARE CENTER** B. WING _____	**01/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	**1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703**

(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 483.70(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 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to properly insure the operability of the sprinkler system as required by NFPA 25 table 2-1 and NFPA 25 5.2.1.2. This condition affected one (1) of five (5) exits in the facility at the time of survey.	K 353	1. Sprinkler company was contacted to replace sprinkler heads on or before 1/31/2020 2. This deficient practice had the ability to affect (55) out of (55) residents.	1/31/20

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

Electronically Signed | 01/31/2020

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
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K 353	Continued From page 1 Findings include: On January 8, 2020 at 9:40 AM, observation revealed corroded sprinkler heads under the Front Canopy area of the facility. This deficiency was also noted on their annual sprinkler inspection conducted by Hi-Tek in 2019.	K 353	3. Administrator in-serviced Maintenance Director on 1/28/2020 on monitoring sprinkler head condition and reporting any issues to Administrator. 4. Maintenance Director or Administrator will make rounds weekly for (4) weeks and monthly thereafter to ensure proper condition of sprinkler heads. Any concerns will be corrected and reported to facility Quality Assurance Committee by the Administrator. 5. This is will be completed by 2/9/2020	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. This deficiency affected all residents in the facility on the day of survey. Findings include:	K 712	1. Fire drill documentation was noted to not have included the time fire drill was conducted, or how fire alarm was activated. 2. This deficient practice had the ability to affect (55) out of (55) residents.	1/31/20

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K 712	Continued From page 2 On January 8, 2020 at 10:20 AM, observation revealed fire drill documentation lacked the following crucial components: 1. Time of which each fire drill was conducted. 2. Lack of audible notification for fire drills conducted between the hours of from 6 am - 9 pm.	K 712	3. Administrator and Maintenance Director were in-serviced by Regional Vice-President on 1/08/2020 for providing detailed documentation on fire drill statement on recording which devices were used to trigger alarm, recording staff participation and follow up on any items that need improvement. Fire drills were conducted on all (3) shifts in the month of January. 4. Administrator will monitor fire drill details monthly going forward. Any deficient practices will be reported to Quality Assurance Committee for necessary corrective actions. Up to and including disciplinary actions. 5. This will be completed by 2/9/2020	

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E 000	Initial Comments ********** Survey conducted on 01/08/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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