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	255182	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 000	INITIAL COMMENTS CI MS #16219 & CI MS #16237 The State Agency conducted an annual recertification along with a complaint survey for MS #16219 and MS #16237 from 9/16/2019 to 9/19/2019. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #16219 for pressure ulcer neglect and MS #16237 for death prevention (facility followed code status) with no citations related to the complaint. The SA cited F565, F577, F640, F757, and F880 during the survey. The census was 97 and the facility held a license for 105 beds.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565		10/17/19

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

Electronically Signed | 10/17/2019

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F 565	Continued From page 1 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview, and review of the facility policy, the facility failed to resolve a grievance concerning a missing item for one (1) of 21 sampled residents, Resident #61. Findings include: Review of the facility policy entitled "Resident and Family Grievance" dated 8/6/2019 revealed, "Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and activity working toward resolution of that complaint/grievance .... 12) The facility will make prompt efforts to resolve a grievance. " During an interview on 9/17/2019 at 2:00 PM, Resident #61 reported she had been missing her green bedspread for a month. She stated she reported to housekeeping at that time the blanket	F 565	* Resident #61's bedspread has been located in laundry by laundry personnel on 10/09/19. No in-service was held as it is standard procedure to look for lost clothing and bedding in laundry. ** All residents have the potential to be affected by this same deficient practice. *** All grievances will be brought to the morning department head meeting, Monday - Friday for review with the proper department. The Social Service Director (Grievance Officer) or appropriate department head will resolve the grievance and the Grievance Officer will provide the resident or responsible party with the written results within 7-14 days. **** Quality Assurance (QA) will review all	

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F 565	Continued From page 2 went missing. In an interview on 09/19/19 at 8:30 AM, Social Worker #1 stated Resident #61's family member had told her about the missing bedspread, but she could not remember when she had told her. Later that day Social Worker #1 provided a grievance written on 9/17/2019. In an interview, 09/19/19 09:45 AM, the Administrator stated when a resident brings up a concern in the Resident Council meeting, the Activity Director brings it up in the morning meeting. The Social worker then looks for the missing items and if she finds the item, she does not always write a grievance. In an interview on 09/19/19 at 10:15 AM, Certified Nursing Assistant #1 stated Resident #1 had a green blanket that had been missing over a week and a half.	F 565	grievances twice monthly for three months to ensure a timely resolution and will bring their findings to the monthly Quality Assurance meeting for review and recommendation.	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		10/17/19

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F 577	Continued From page 3 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on resident interviews, observations, and facility statement/policy, the facility failed to ensure residents were aware of the location and availability of the most recent survey results, this affected four (4) of five (5) residents who attended the Resident Council group meeting, who complained they were unaware of the location of the survey results. Findings include: Review of the facility statement/policy, dated 9/19/19, revealed the facility posts the location of the State Survey Book on the bulletin board in the front hallway. During the Resident Council meeting on 9/17/2019 at 2:00 PM, four (4) of five (5) residents complained they were unaware of the location of the survey results. On 09/19/19 at 8:30 AM, interview with Social Worker #1 revealed she did not know where the survey results were posted in the facility. The survey results were observed on 9/19/2019	F 577	* The four of five residents were informed by the Activity Director on 09/17/19 of the locations of the most recent survey results. ** All residents have the potential to be affected by this same deficient practice. *** Signs have been placed in the front hallway bulletin board, the 500 hall bulletin board and in the Activity Room stating the location of our most recent survey results. Survey results are located in binders labeled "State Survey Book". Survey books are located both in the Activity Room and the sitting room at the end of the 300 hall. Both rooms are open 24 hours a day, seven days per week. The location of the survey results books will be announced to the residents by the Activity Director each month during the Resident Council meeting and noted in the meeting minutes. The first meeting with this announcement made was held on 10/15/19.	

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F 577	Continued From page 4 at 8:35 AM, posted in the far corner of the activity room, which is not always readily accessible (such as a lobby or other area frequented by most residents, visitors or other individuals) where individuals wishing to examine survey results do not have to ask to see them. The notice was posted on the board "Located in our activity Department you will find a copy of our most recent State Board of Health Survey Results", with a lot of other information. This was not in the front hallway.	F 577	**** Quality Assurance nurse will review the Resident Council minutes once per month for three months to ensure that the announcement was made and will bring their findings to the monthly Quality Assurance meeting for review and recommendations.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		10/17/19

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F 640	Continued From page 5 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on Record Review, Staff Interview, and facility policy Review, the facility failed to transmit the Minimum Data Set (MDS) in a timely manner for four (4) of four (4) residents reviewed for MDS transmission, of 24 sampled residents reviewed, Residents #1, #3, #6, and #7. Findings Include: Review of a signed statement on facility letterhead, dated 9/19/19, and signed by the Administrator, revealed the facility followed the Resident Assessment Instrument (RAI) Manual guidelines for submitting the MDS.	F 640	* Assessments for Residents #1, #3, #6 and #7 have been submitted by Minimum Data Set(MDS) nurses. ** All residents have the potential to be affected by this same deficient practice. *** MDS will run an Assessment Summary Report once weekly beginning 09/23/19 to look for any outstanding MDS assessments that have not been transmitted. Any assessments not transmitted listed on the report will be transmitted.	

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F 640	Continued From page 6 Record Review of the Resident Assessment Instrument (RAI) Manual, used by the facility for policy requirements, revealed the Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment, Annual assessment, Significant change in status assessment, Significant correction of prior full assessment, Significant correction of prior quarterly assessment, Quarterly review, A subset of items upon a resident's transfer, reentry, discharge, and death, Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. Resident #1 Record Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 7/8/2019, revealed the MDS was not transmitted to Centers for Medicare & Medicaid Services (CMS) until 9/18/2019. Resident #7. Record Review of Resident #7's MDS, with an ARD of 8/1/2019, revealed the MDS was not transmitted to CMS until 9/18/2019. Resident #3 Review of Resident #3's yearly MDS, with the ARD date of 7/30/2019, revealed the MDS was not submitted to CMS until 9/17/19, and should have been completed and submitted by 7/30/19. Resident #6 Review of Resident #6's Quarterly MDS, with the ARD date of 8/9/2019, revealed the MDS was not	F 640	**** Quality Assurance (QA) nurse will monitor the Assessment Summary reports twice monthly for a period of three months to ensure timely submission. QA will bring their findings to the monthly QA meeting for review and recommendations.	

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F 640	Continued From page 7 transmitted to CMS until 9/19/2019, which is more than 14 days past the due date. During an interview on 09/19/19 at 05:10 PM, RN #1 confirmed the MDS's were late. The nurse said they printed out the assessment summary and noticed they had missed four (4) MDS's that had not been submitted. The nurse said she submitted the MDS's on 9/18/2019 for Residents #1, #7, #3 and #6.	F 640		
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 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	F 757	* Resident #48's medication was	10/17/19

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F 757	Continued From page 8 Facility Policy Review, the facility failed to prevent the use of unnecessary medication for one (1) of seven (7) residents reviewed for unnecessary medications, Resident #48. Resident #48 was given medication for the diagnosis of Schizophrenia, after admission, with no prior history of this mental illness. Findings include: The facility's policy, "Use of Psychotropic Drugs", not dated, noted the indications for initiating, as well as the use of non-pharmacological approaches, will be determined by: The indications for use of any psychotropic drug will be documented in the medical record. 2.3 Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. 2.4 For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. 2.4.1 Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. Review of current Physician's orders, revealed Resident #48 had orders for Seroquel 25 milligram (mg) at bedtime. In an interview on 9/19/19 at 12:48 PM, the Pharmacy Consultant stated Resident #48 did not have a diagnosis of Schizophrenia on admission orders, nor was she taking Seroquel 25 milligram (mg) daily at bedtime. In an interview on 09/19/19 at 1:33 PM, the	F 757	reviewed and discontinued on 09/25/19. ** All residents have the potential to be affected by this same deficient practice. *** The Admission Nurse will review the medication list for all new admissions to ensure the correct diagnosis is present for any psychotropic medications. No in-service was done. **** Quality Assurance (QA) nurse will monitor psychotropic medications by bringing new resident's charts to morning department head meeting Monday-Friday for review by the interdisciplinary team. Their findings will be brought to the monthly QA meeting for review and recommendations.	

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F 757	Continued From page 9	F 757		

Director of Nursing (DON) stated she was not sure why a diagnosis of Schizophrenia was added after Resident #48 was admitted.

In an interview on 09/19/19 at 2:41 PM, Licensed Practical Nurse (LPN) #1/ Minimum Data Set (MDS) Nurse, confirmed the Quarterly MDS on 6/24/19, does not list Schizophrenia as a diagnosis. She also confirmed Resident #48 did not have a baseline Care Plan to address the diagnosis of Schizophrenia, and if is listed as a diagnosis, there should be a care plan for it.

In an interview on 09/19/19 at 2:51 PM, the Medical Director and Resident #48's Primary Care Physician (PCP) stated that he was unable to find where the initial diagnosis of Schizophrenia came from for Resident #48. The PCP stated on review the progress notes from two (2) separate hospital progress notes, revealed no diagnosis of Schizophrenia prior to admission. The PCP stated the progress notes from a local hospital on 1/14/19, also did not reveal a diagnosis of Schizophrenia. The PCP confirmed he wrote a diagnosis of "Labeled as Schizophrenic, but stated, "I did not necessarily agree with that."

During an interview on 09/19/19 at 3:15 PM, the DON confirmed the Pre-Admission Screening Resident Review (PASRR) Level II, dated 7/17/19, revealed Resident # 48 did not have sufficient documentation to support a diagnosis of Schizophrenia or Mental Illness, and did not have evidence of the need for Seroquel.

In an interview on 09/19/19 at 3:47 PM, Resident #48 stated she had never had a diagnosis of Schizophrenia. Resident #48 stated years ago

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F 757	Continued From page 10 when she was having family problems, a doctor told her she was upset because all women are neurotic. Resident #48 denied ever having other psychiatric concerns prior to admission. A review of the Admission Physician Orders for Resident #48, dated 2/1/19, revealed no diagnosis that included Schizophrenia, and no orders for Seroquel. The facility admitted Resident #48 on 3/26/19, with the diagnoses which included: Acute Respiratory Failure with Hypoxia, Congestive Heart Failure, and Type 2 Diabetes Mellitus.	F 757		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/17/19

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F 880	Continued From page 11 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on Observation, Staff Interview, Record Review, and Facility Policy review, the facility failed to prevent the possible spread of infection by not cleaning Blood Pressure cuffs during medication Administration two (2) of four (4) Medication Pass Observations. Findings Include: Record Review of the facility's policy titled, "Infection Control Policy" with an effective date of 1/1/07, revealed it is the policy of this facility to maintain an infection control program as follows: designed to provide a safe, sanitary, comfortable environment to help prevent the development and transmission of disease and infection. Observation on 9/18/2019 at 4:51 PM, of a medication pass with Licensed Practical Nurse (LPN) #3, revealed the nurse failed to clean the blood pressure cuff between resident contact of Residents #62 and #66. During an interview on 9/19/2019 at 2:58 PM, LPN #3 confirmed she pulled the cuff out of her pocket and failed to clean the blood pressure cuff in between both residents, Resident #62 and Resident #66. During interview on 9/19/2019 at 3:30 PM, the Director of Nursing (DON) confirmed the nurse should not put the blood pressure cuff in her pocket. The DON also said the nurse should	F 880	* All blood pressure cuffs have been disinfected by medication nurses on 09/19/19. ** All residents have the potential to be affected by this same deficient practice. *** A new policy was written on 09/20/19 by the interdisciplinary team and approved by the Medical Director for the "Cleaning and Disinfection of Resident Care Equipment" to include "multiple-resident use equipment shall be cleaned and disinfected after each use". All nurses have been in-serviced on the new policy beginning on 09/20/19 and ending on 10/15/19 and the proper cleaning of blood pressure cuffs between use. **** Quality Assurance (QA)nurse will audit one medication pass per week for infection control discrepancies for a period of three months and will bring their findings to the monthly QA meeting for review and recommendations.	

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	255182	A. BUILDING _____ B. WING _____	09/19/2019

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F 880	Continued From page 13 clean the blood pressure cuff after each use, between residents. A review of the facility's face sheet revealed the facility admitted Resident #62 on (12/14/2016), with diagnoses, which included Hypertension, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease . A review of the facility's face sheet revealed the facility admitted Resident #66 on (5/10/2013), with diagnoses, which included Diabetes Mellitus, Hypertension and Major Depressive Disorder.	F 880		

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	255182	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**09/16/2019**

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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 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		10/7/19

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

Electronically Signed | 10/17/2019

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K 324	Continued From page 1 Based on observations, the facility failed to provide protect the cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.6.2. The deficient practice affected all smoke compartments and residents in facility on the day of survey. Findings Include: On 9/16/19 at 10:20 AM, observation revealed yellow deficiency tag on the kitchen vent hood from the local AHJ. The yellow deficiency stated the extinguishing system of the kitchen vent hood was incapable of activating the fire alarm system in the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 9/16/19.	K 324	* The vent hood was repaired on 10/07/19 by E Fire Southern. Attached is the Range Hood System Report and corresponding invoice. ** All residents have the potential to be affected by this same deficient practice. *** Maintenance will inform Administrator of any non-functioning parts of the fire alarm system immediately for follow up of completion or correction. **** QA will monitor fire inspection reports for completion for a period of one year. QA will bring their findings to the monthly QA meeting for review and recommendations.	
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	K 712		10/8/19

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K 712	Continued From page 2 by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. The deficient practice affected all smoke compartments and residents in facility on the day of survey. Findings Include: On 9/16/19 at 9:00 AM, the facility could not provide complete documentation showing fire drills performed during the four (4) quarters of last calendar year. The following fire drill documentation was not provided during the survey: 1. The 1st quarter of 2019 2. 4th quarter of 2018 The finding was acknowledged by the Administrator verified this observation during the exit interview on 9/16/19. The Administrator stated the fire drill documentation 1st quarter of 2019 and 4th quarter of 2018 were disposed and thrown away.	K 712	* Maintenance was in-serviced on 09/30/19 on paperwork retention. All current and future paperwork relating to fire drills will be brought to the Administrator for proper record keeping. In-service is attached. ** All residents have the potential to be affected by this same deficient practice. *** The Maintenance Record Book will be kept in the Administrators office. No paperwork will be disposed of or thrown away without the express approval of the Administrator. The Administrator and Maintenance personnel will review the documentation monthly for accuracy and completeness. **** QA will monitor the Maintenance Record Book quarterly for correct documentation of fire drills and bring their findings to the QA monthly meeting for review and recommendations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		10/2/19

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K 918	Continued From page 3 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on the review of documentation, the facility failed to properly document records of testing the generator annually as directed by NFPA 99 sections 6.4.4.1.1.3 and 6.4.4.2. This deficient practice had potential of affecting the entire facility on the day of facility survey. Findings include: On 9/16/19 at 9:15 AM, the facility could not produce most the documentation for monthly load test and weekly inspection of the generator with the last calendar year of 2018 and 2019.	K 918	* Maintenance was in-serviced on 09/30/19 on document retention. Maintenance has been instructed to turn all current and future paperwork pertaining to the generator testing in to the Administrator for proper record keeping. In-service is attached. ** All residents have the potential to be affected by this same deficient practice. *** The Maintenance Record Book will be kept in the Administrators office. No	

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K 918	Continued From page 4 The finding was acknowledged by the Administrator verified this observation during the exit interview on 9/16/19. The Administrator stated most the documentation for monthly load test and weekly inspection of the generator were disposed and thrown away.	K 918	paperwork will be disposed of or thrown away without the express approval of the Administrator. The Administrator and Maintenance personnel will review the book monthly for accuracy of paperwork. **** QA will monitor the Maintenance Record Book monthly for 6 months for correct documentation of weekly and monthly load tests of the generator and bring their findings to the QA monthly meeting for review and recommendations.	

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E 000	Initial Comments ********** Survey conducted on 09/16/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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