STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	**209 OAK CIRCLE/P. O. BOX 198 DUNCAN, MS 38740**

(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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey, at the facility, from 03/09/2020 to 03/12/2020. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F656. At the time of the survey, the facility had a census of 57, and held a license for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		4/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/21/2020

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 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to develop a care plan to address the use of an anticoagulant, for one (1) of 15 resident care plans reviewed, Resident #53. Findings include: A review of the facility's "Care Plans - Comprehensive" policy, revised September 2010, revealed: "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Record review of the March "Physician Orders" for Resident #53, revealed an order for the anticoagulant, Eliquis 5 milligrams (mg) by mouth (PO) twice a day (BID) for stroke prevention, with an order date of 01/22/2018.	F 656	483.21(b)(1)Develop/Implement Comprehensive Care Plan (LONG TERM CARE FACILITIES) Bullet 1. Correction actions accomplished for alleged deficient practice: A. On 3/11/2020, a 100% audit was done by the Director of Nursing and Care Plan Nurse on anticoagulant medicines in the facility to address the use of an anticoagulant. B. On 3/11/2020, a 100% completion of Care Plan was done by the Care Plan Nurse on all Residents being administered anticoagulant medicine, including Resident #53, to address the use of an anticoagulant.	

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	25E115	A. BUILDING ______ B. WING ______	03/12/2020

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F 656	Continued From page 2 A review of the February and March 2020 Medication Administration Record (MAR) for Resident #53, revealed, Eliquis was being administered twice a day as ordered by the physician. Review of Resident #53's comprehensive care plan, revealed, there was not a care plan to address the use of an anticoagulant. A review of Resident #53's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2020, revealed, Section N0410E (Medication received), was coded to indicate the resident received an anticoagulant for seven (7) days, during the lookback period for this assessment. During an observation, on 03/11/2020 at 9:37 AM, revealed, Resident #53 had no abnormal bruising or bleeding noted. An interview, with the Director of Nursing (DON) and Registered Nurse (RN) #1/MDS Assessment Nurse, on 03/11/2020 at 10:20 AM, revealed, Resident #53 was receiving Eliquis twice a day, and should have had a care plan for the anticoagulant, but it was not included. A review of the facility's "Face Sheet" for Resident #53, revealed, she was admitted by the facility, on 08/02/2012, with diagnoses which included Psychotic Disorder with Hallucinations, Anxiety Disorder, Essential Hypertension, and Paroxysmal Atrial Fibrillation.	F 656	C. On 3/11/2020, the Administrator and the Director of Nursing located and reviewed Policy on Care Plans to ensure compliance with regulation, including Resident #53. D. On 3/11/2020, a 100% body audit was completed on all Residents by the Assistant Director of Nursing noted to be on anticoagulant drug therapy, including Resident #53. E. On 3/11/2020, the Medical Director was notified by the Director of Nursing of Care Plans and current orders reviewed by the Director of Nursing. F. On 3/11/2020, Resident #53 was assessed and had no abnormal bruising or bleeding upon review by the Assistant Director of Nursing. G. On 04/02/2020, 4/9/2020, and 4/16/2020, Resident #53 had no abnormal bruising or bleeding upon review by the Assistant Director of Nursing. Bullet 2. All residents have potential to be affected by this deficient practice. Bullet 3. Measure put in place to ensure the alleged deficient practice does not reoccur. A. On 3/11/2020, an in-service was completed with all nursing staff and Certified Nursing Assistants by the	

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	25E115	A. BUILDING _____ B. WING _____	03/12/2020

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F 656	Continued From page 3	F 656	Director of Nursing on anticoagulants and the side effects of anticoagulant. B. On 3/11/2020, all nursing staff, the Direct of Nursing, and Care Plan Nurse was in-serviced by the Administrator of the importance of addressing all Residents on anticoagulant therapy, with weekly skin assessment, prn skin assessment, skin issues, notification of Medical Director, labs as directed and proper care plans. C. On 3/11/2020, the Treatment records will be reviewed by the Assistant Director of Nursing for proper documentation on skin audit. D. The Medication records will be reviewed by the Director of Nursing and Charge Nurses monthly for proper anticoagulant order. E. All written orders to be reviewed Monday thru Friday by the Director of Nursing beginning, 3/11/2020. F. Care plans will be updated Monday thru Friday by the Care Plan Nurse beginning, 3/12/2020. Bullet 4. The Director of Nursing will review orders Monday thru Friday in morning meeting. All orders will be given to the Care Plan Nurse for proper care planning. The Director of Nursing is responsible to ensure all orders have been transcribed correctly. The Director of Nursing will monitor this deficient	

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F 656	Continued From page 4	F 656	practice beginning 3/16/2020, weekly Monday thru Friday x eight weeks and then two weeks x four and then monthly. The Director of Nursing will report finding to the Quality Assurance Committee on a quarterly basis. Quality Assurance will review findings and make recommendations for changes and/or revisions as needed.	

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	25E115	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/09/2020

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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 712 SS=D	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 section 19.7.1.2. This deficiency affected all residents in the facility on the day of survey Findings Include: On 3/9/2020 at 10:20 AM, the facility could not provide complete documentation showing fire drills performed during the of last calendar year. The following fire drill documentation was not provided during the survey: 1. 1st, 2nd, or 3rd shifts of the 4th quarter of	K 712	NFPA 101 Free Drills (LSC 2012 Health Existing) Bullet 1. Correction actions accomplished for alleged deficient practice: A. On 3/12/2020 staff meeting held on fire drill safety, responding, signage of in-service sheet. B. On 3/14/2020 a fire drill was held for 11-7 (NIGHT) shift. All present	4/21/20

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Electronically Signed		04/21/2020

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	25E115	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**03/09/2020**

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K 712	Continued From page 1 2019. The administrator was made aware of the issue during the exit conference.	K 712	employees responded and educated on the importance of the fire drill. C. On 4/05/2020 a fire drill was held for 3-11 (EVENING) shift. All present employees responded and educated on the importance of the fire drill. D. Record of fire drill to be kept in a binder in the Administrator office and a second copy to be retained in Human Resource office. Bullet 2. All residents have the potential to be effected by this deficient practice. Bullet 3. Measures have been put in place to ensure alleged deficient practice does not reoccur: A. Maintenance Staff have been in serviced by Administrator on 03/11/2020 on the importance of quarterly fire drills and maintaining a log to show completion. B. The fire drill signage sheet will be retained in the Administrator office and a copy retained in Human Resource office. Bullet 4. Administrator will monitor this deficient practice monthly for 12 months. Administrator will report finding to the Quality Assurance committee on a quarterly basis. Administrator is responsible to ensure compliance with Fire Drill requirements/regulations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 03/09/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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