STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255291	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

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F 000	INITIAL COMMENTS A standard recertification survey was conducted by Ascellon, on behalf of the Mississippi State Department of Health, from May 6, 2019 through May 9, 2019. The standard survey revealed the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F-553, F-641, F-812. The facility's census on May 6, 2019 was 55 residents and the facility held a license for 60 beds.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		6/15/19

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

Electronically Signed | 06/14/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 553	Continued From page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, the facility failed to provide residents the right to participate in the development and implementation of their person-centered plans of care for three (3) of four (4) sampled residents reviewed for care plan participation, Resident #7, Resident #14 and Resident #35, by not inviting them to participate in their scheduled care plan meetings. Findings include: Review of the facility's policy entitled, "Family and/or Resident Input-Care Planning Process" revised February 2017, revealed residents and families on admission and thereafter should be invited to all Care Plan Conferences. Resident #7 Interview with Resident #7 on 5/6/19 at approximately 4:10 PM, revealed she had not been invited to any care plan meeting or any meeting to discuss her care. Review of the Admission Minimum Data Set (MDS) assessment, with an Assessment	F 553	1) On May 7, 2019, the facility's Social Services Director met with Resident #35 and discussed care plan review. On June 10, 2019, the facility's Social Services Director met with Resident #7 and Resident #14 and discussed care plan review. 2) On June 12, 2019, the facility's Social Services Director audited the care plan review calendar for the months of May and June 1 - 12 of 2019 and determined zero (0) out of 36 residents scheduled for the care plan review was not invited. 3) On May 7, 2019, the facility's Director of Nursing in-serviced the facility's Social Services Director on Family and/or resident input-care planning process. On May 13, 2019, the Quality Assurance Committee reviewed the policy, "Family and/or Resident Input-Care Planning Process," with no recommended changes to policy. 4) The facility's Administrator and/or	

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F 553	Continued From page 2 Reference Date (ARD) of 6/7/18, revealed Resident #7 scored 14 on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. In addition to the Admission MDS, Resident #7 was assessed quarterly on 9/4/18, 11/28/18, and 2/20/19. In the most current MDS assessment completed for Resident #7, she scored a 14 on the BIMS. Review of the Social Services Progress Notes for 9/2018, 11/2018, and 2/2019, for Resident #7, revealed no note had been documented that would indicate the resident attended the care plan meeting held in September 2018. Interview with the Social Services Director (SSD) on 5/9/19 at approximately 10:20 AM, revealed staff filled out a check list to indicate if the resident was invited to his/her care plan meeting. Review of the check list entitled "Care Plan Review", with the SSD, revealed no documentation which would indicate Resident #7 had been invited to the September 2018 meeting. Resident #14 Interview with Resident #14 on 5/7/19 at approximately 9:35 AM, revealed she had never heard of a care plan meeting and did not recall getting invited to attend one. Review of the Admission MDS assessment with an ARD of 6/24/18, revealed Resident #14 scored three (3) on the BIMS, which indicated severely impaired cognition. In addition to the Admission MDS Resident #14 was assessed quarterly on 9/18/18, 12/18/18, and 3/6/19. The 3/6/19 MDS assessment completed for Resident #14 showed she scored a 14 on the BIMS, which indicated her cognition was intact.	F 553	Director of Nursing will review Minimum Data Set calendar schedule monthly for four (4) months and will audit 10 residents' social notes, care plan meeting letter and care plan review form to ensure that residents are invited to the care plan meeting beginning June 10, 2019. The Quality Assurance Committee will evaluate the audits completed by the facility's Administrator monthly for three (3) months and make recommendations and changes to ensure compliance.	

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F 553	Continued From page 3 Review of the Social Services Progress Notes for 9/2018, 12/2018, and 3/2019, for Resident #14, revealed an entry was completed on 3/12/19 at 12:11 PM, which indicated the resident's representative did not attend the meeting and a message was left. No documentation indicated Resident #14 had been present or invited. Review of the "Care Plan Review" form for Resident #14 revealed a resident care conference was held on 3/12/19, and the resident was marked as not being invited. Interview with the SSD on 5/9/19 at approximately 10:16 AM, revealed Resident #14 had not come to her care plan meeting, and she did not have any documentation to indicate the resident was invited. Interview with the MDS Nurse on 5/9/19 at approximately 10:35 AM, regarding Resident #14, revealed she filled out the "Care Plan Review" checklist for the resident, but she could not recall why she marked the resident was not invited. Resident #35 On 5/6/19 at 5:47 PM, during an interview, Resident #35 stated she had suffered a stroke several months ago and had voiced concerns to staff regarding her anticipated discharge to home following the completion of her rehabilitation. She stated she had asked nursing several times, regarding her plans for discharge, and was not able to receive a tentative answer by anyone. Resident #35 was admitted to the facility on 2/14/19, with diagnoses including Cerebrovascular Accident with Right Side	F 553		

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F 553	Continued From page 4 Hemiparesis, Major Depressive Disorder and Anxiety Disorder. Review of the Admission MDS assessment with an ARD of 4/12/19, revealed Resident #35 scored 6 on the BIMS, which indicated severe cognitive impairment. Prior to having the stroke, Resident #35 had lived at home with her husband. Review of the Physician's Orders dated 2/14/19, indicated Occupational Therapy (OT) and Physical Therapy (PT) were to treat five (5) X (times) per week for 60 days along with Speech Therapy (ST) to treat six (6) X per week for 60 days to prepare the resident to return to home with home health and sitters provided by the responsible party. In an interview on 5/9/19 at 9:36 A.M., the SSD stated she always sent an invitation to the responsible party inviting them to the Care Plan meeting and verbally invited each resident informing them of the date and time of their next Care Plan meeting. The SSD stated, "I assumed the family was inviting the Resident (#35) and should have personally invited her as I do with all the other residents. I missed inviting her. I will talk with the Resident (#35) and inform her of the plans discussed at the Care Plan Meetings." In an Interview on 5/9/19 at 11:36 AM, OT #2 stated Resident #35 was making great progress with therapy and the plans were for her to go home the end of May with help to do activities of daily living (ADLs). "The family has agreed to provide the help as needed. I do not remember the resident (#35) being present at any of the Care Plan meetings."	F 553		

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F 553	Continued From page 5 Review of care plan invitations dated 2/26/19 and 4/19/19, for Resident #35 indicated family members were invited to both meetings.	F 553		
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 and staff and resident interviews, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the residents' status at the time the assessment was completed for two (2) out of 21 residents whose records were reviewed (Resident #23 and Resident #57). Findings include: Resident #23 Review of the medical record for Resident #23 revealed he was admitted to the facility on 12/18/18. Review of weight records revealed his weight upon admission was 384 pounds. His weight on 1/15/19 was documented at 332 pounds, showing a loss of 52 pounds or 13.54% in one (1) month. He was discharged to the hospital on 2/6/19, and readmitted to the facility on 2/15/19. His weight on readmission was 327 pounds (a weight loss of five pounds while hospitalized). This was a weight loss of 57 pounds or 14.84% in two (2) months. His weight on 3/12/19, was 288 pounds. This was a weight loss of 96 pounds or 25% in three (3) months. His documented weight on 5/7/19 was 251 pounds, showing a weight loss of 133 pounds or	F 641	1) On June 10, 2019, Resident #23 Quarterly Minimum Data Sets and 30 day Minimum Data Sets was modified and the facility's Dietary Manager corrected Section K (Nutritional Section). Resident #57 discharge Minimum Data Sets was modified and was corrected by the facility's Nurse Case Manager on June 12, 2019. 2) On June 11, 2019, the facility's Dietary Manager audited Minimum Data Sets completed from the last quarter and determined four (4) out of 75 Minimum Data Sets reviewed needed to be corrected. These four (4) Minimum Data Sets were corrected by the facility's Dietary Manager on June 11, 2019. On June 11, 2019, the facility's Director of Nursing audited Minimum Data Sets discharged from last quarter and determined two (2) out of 36 Minimum Data Sets reviewed needed to be corrected. 3) On May 8, 2019, the facility's Director of Nursing in-serviced Dietary Manager on	6/15/19

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F 641	Continued From page 6 34.64% in five (5) months. The Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/27/18, noted a weight of 384 pounds with no significant weight loss. A Significant Change MDS assessment with an assessment reference date (ARD) of 2/22/19, showed the weight of Resident #23 as 327 pounds and no significant weight loss had occurred. Weight records revealed Resident #23 had a weight loss of 57 pounds or 14.84% in less than six (6) months which was a significant weight loss (10% or more in 6 months). A Quarterly MDS assessment with an ARD of 3/14/19, identified the weight of Resident #23 as 311 pounds on 3/5/19, and documented there was no significant weight loss. This was a weight loss of 73 pounds or 19.01% in less than six (6) months since admission and was a significant weight loss (10% or more in six (6) months). A 30-day MDS assessment was completed for Resident #23 with an ARD of 3/27/19 (30 days after readmission from the hospital). The swallowing and nutritional assessment identified the current weight of Resident #23 as 268 pounds on 3/19/19, and documented there was no significant weight loss. This was a significant weight loss of 59 pounds or 18.04% in one (1) month. In an interview on 5/8/19 at 2:30 PM, in her office, the Nurse Case Manager revealed the Dietary Manager completed the swallowing and nutritional assessment section of the MDS.	F 641	Section K0300 (Weight Loss) and Nurse Case Manager on Section A2100 (Discharged Status) from Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 manual and the importance of coding correctly. 4) The facility's Administrator and Director of Nursing will review five (5) Minimum Data Sets weekly, beginning May 24, 2019 before facility transmits to ensure that Section K0300 (Weight Loss) and Section A2100 (Discharged Status) was coded correctly. The Quality Assurance Committee will evaluate the audits completed by the facility's Administrator and Director of Nursing monthly for three (3) months and make recommendations and changes to ensure compliance.	

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F 641	Continued From page 7 Interview with the Certified Dietary Manager (CDM) on 5/9/19 at 3:00 PM, adjacent to the nurses' station, confirmed she completed MDS section for swallowing and nutritional status assessment. After review of the MDS assessments for Resident #23, the CDM stated she made a mistake when she marked no significant weight loss. She stated she was aware he had a significant weight loss and said "Resident #23 should have been assessed with a "1" (indicating the resident experienced a significant weight loss and was on a physician prescribed weight loss regimen) instead of a zero (0) to indicate no significant weight loss occurred." She stated she had completed care plans and the Dietician had assessed him for his weight loss. She stated, "I made a mistake when I was completing nutritional status section for Resident #23." Interview with the Director of Nursing (DON) in her office, on 5/7/19 at 11:30 A.M. confirmed Resident #23 had a significant weight loss due to fluid loss/diuresis since his admission. Interview with Resident #23 on 5/9/19 at 9:20 AM, revealed him to be alert and oriented to person, place, and time with no cognitive impairment. He reported he lost about 130 pounds since his admission and stated he had not felt this good in years. He reported he had 16 episodes of congestive heart failure (CHF) since 2011, and almost died several times. He stated this was the longest period of time he had ever been able to keep the fluid weight off, sometimes gaining up to 50-70 pounds in a week. He stated upon admission he was on Hospice, was bed bound and oxygen dependent. Now he stated he got out of bed, went to activities, went on outings and	F 641		

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F 641	Continued From page 8	F 641		

was able to do things for himself he had not been able to do in a long time. He stated he also no longer used oxygen routinely.

All the MDS assessments requiring nutritional status to be completed following the Admission MDS documented no significant weight loss for Resident #23, even though he had a loss of 34.64% of his body weight in less than six (6) months and the parameter for significant weight loss was met at each assessment.

Resident #57
Review of medical record for Resident #57 revealed she was admitted to the facility 2/20/19, from an acute care facility. She had been admitted for a short term stay and a planned discharge was noted in the Social Service Progress Notes. Discharge planning included instructions, medications, home health, durable medical equipment and copies of medical information (lab and x-ray results) to be given to her primary care physician after discharge. Resident #57 was discharged home with her daughter on 3/22/19.

Review of the discharge MDS assessment with an ARD of 3/22/19, noted the documentation in Resident #57's medical record was discharged to an acute care facility.

During an interview in her office on 5/9/19 at 2:15 PM, the Nurse Case Manager who completed the discharge MDS for Resident #57, revealed the assessment was incorrect. She stated, "This resident went home and not to the hospital. We will have to do a correction."

The incorrect discharge location of acute care

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F 641	Continued From page 9 facility instead of home, documented on the discharge MDS assessment did not accurately reflect the status of Resident #57.	F 641		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of policies and procedures, the facility failed to: ensure staff knew how to calibrate thermometers, store plates and trays in a sanitary and safe manner, maintain the ceiling in the kitchen in clean manner and in good repair, discard expired items, label and date food/beverage items, and monitor the temperature in the residents' pantry refrigerator. These failures created the potential for the spread of foodborne illness to all 55 residents in	F 812	1) On May 8, 2019, the facility's Dietary Manager calibrated all thermometers and the Dietary Manager and Food Service Employee wiped and dried all stacked meal trays, plates, bowls, and cups. On May 8, 2019 the facility's Maintenance Supervisor was notified about air conditioner vent near dry storage area where it was found that popcorn ceiling had come apart from the dry wall and part of the ceiling near air conditioner vent in	6/15/19

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F 812	Continued From page 10 the facility. Findings include: Per the United States Department of Agriculture Food Safety and Inspection Services the following is how to calibrate a dial stem thermometer in ice water: "To use the ice water method, fill a large glass with finely crushed ice. Add clean tap water to the top of the ice and stir well. Immerse the food thermometer stem a minimum of two (2) inches into the mixture, touching neither the sides nor the bottom of the glass. Wait a minimum of 30 seconds before adjusting. (For ease in handling, the stem of the food thermometer can be placed through the clip section of the stem sheath and, holding the sheath horizontally, lowered into the water.) Without removing the stem from the ice, hold the adjusting nut under the head of the thermometer with a suitable tool and turn the head so the pointer reads 32 °F." Review of facility policy entitled "Food Storage Labeling" revised on May 2018, revealed the following: 4. Monitoring storage temperatures. a. A thermometer is kept in all storage areas. b. Temperatures in food storage units are monitored daily. c. Documentation of time and temperature is recorded on a "Temperature Monitoring Log." Kitchen observations on 5/8/19 at 10:52 AM, revealed Food Service Worker (FSW) #1 was asked prior to taking the temperatures of the food on the lunch meal tray line if she could calibrate the thermometer. During the observation FSW #1 was observed with a cup of water with small	F 812	dish room had a black stain. All expired items and items not labeled were discarded by facility's Dietary Manager on May 8, 2019. On May 8, 2019, the facility's pantry refrigerator was cleaned and a thermometer was place in refrigerator. Documentation on the refrigerator temperature log began on May 8, 2019 by the facility's Dietary Manager. 2) On June 13, 2019, the facility's Dietary Manager reviewed Dietary orders and determined that 53 out of 54 residents have the potential to be affected by the spread of foodborne illnesses due to this deficient practice. 3) On May 8, 2019, the facility's Dietary Manager in-serviced Dietary Staff regarding calibrating thermometers properly and in-serviced Dietary Staff on expired food items. On May 9, 2019, the facility's Dietary Manager in-serviced Dietary Staff regarding proper storage and drying of plates, trays, and bowls in a sanitary and safe manner. On May 8, 2019, the facility's Dietary Manager in-serviced Dietary Staff on labeling food/beverage items and proper monitoring of the temperature in the resident pantry refrigerator. On May 14, 2019, the facility's Maintenance Supervisor made contact with the facility's contractors to discuss findings from survey and set a date of June 13, 2019 to repair ceiling around air conditioner vents and to clean/repair black stain located in facility's dietary dish room. On June 13,	

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F 812	Continued From page 11 amount of ice, she was then asked what the dial stem thermometer should read when calibrated and she said zero (0). She was then seen obtaining more ice for the water for the cup being used to calibrate the thermometer. She once again placed the dial stem thermometer in the cup of ice water and once again it read zero (0). When asked how she would fix that, she was observed trying to get the sheath out to adjust the lug but was not successful. While observing the lunch tray line service it was noted that approximately 30 meal trays were stacked one (1) on top of each other and were wet. Residents' plates and other cups, bowls, etc. were placed on the wet trays. In addition to the wet nesting trays, 15 plates that had been stacked wet, were observed being used to serve residents' meals. Further observation of the kitchen, during the tray line service on 5/8/19 at approximately 11:41 AM, revealed: the popcorn finish of the ceiling around one (1) of the edges of air conditioning ceiling vent near the dry storage was coming off, near the ceiling vent over one (1) corner of the kitchen hood was an area where the popcorn finish of the ceiling had come apart from the dry wall, and a part of the popcorn finish of the ceiling near the ceiling vent located in the dish machine room was noted to have a black stain. An observation of the snack cooler on a cart near the entrance to the main dining room on 5/8/19 at approximately 1:15 PM, revealed it had melted water inside and two (2) four (4) ounce strawberry yogurts dated 5/7/19. At approximately 1:25 PM on 5/8/19, observation was made of the nourishment pantry along with the Certified Dietary Manager (CDM), which	F 812	2019, repair to the ceiling around air conditioner vents and the black stain located around air vent in facility's dietary dish room was completed and repaired by outside contractors. 4) On May 9, 2019, the facility's Dietary Manager started to observe one (1) food service employee each day, five (5) times a week for one (1) week. The facility's Dietary Manager then observe one (1) food service employee one (1) day each week for four (4) weeks to ensure that the food thermometers are calibrated correctly. On May 9, 2019, the facility's Dietary Manager started to observe food service employees daily for five (5) days for one (1) week and once a week for four (4) weeks to ensure that dishes and meal trays are stored and dried in a sanitary and safe manner. On May 8, 2019, the facility's Dietary Manager and/or food service employee started the process of checking and documenting the temperature of the resident's pantry refrigerator daily. On May 9, 2019, the facility's Dietary Manager and/or food service employee started the process of checking the Resident's pantry refrigerator and the kitchen refrigerator once a week to ensure that expired food items are discarded and food/beverages are labeled and dated. The facility's Maintenance Supervisor will inspect ceiling once a week for the next two (2) months and make recommendations and changes to ensure compliance. The Quality Assurance Committee will evaluate the audits/documentation completed by the	

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	255291	A. BUILDING _____ B. WING _____	05/09/2019

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F 812	Continued From page 12 revealed the refrigerator was being used to store both staff and residents' food items. In the refrigerator the following issues were noted: a 16.9-ounce bottle of extreme sweet tea was noted to be opened with no name documented, a 12 ounce can of grape soda with no name documented, a 20-ounce bottle of lemonade with no name documented, a small round plastic container with a lid with tomatoes and cucumbers with salad dressing with no name documented. Further observation of the refrigerator revealed the freezer had no thermometer inside to monitor the internal temperature. The freezer was dirty with a yellowish orange sticky substance that had a plastic bag stuck in it, and a 12 ounce can of cola opened. Interview with the CDM while making the observations revealed she no thermometer was kept in the freezer, staff items had always been stored in that refrigerator with residents' items, and the inside of the freezer was not clean. She also confirmed that the same policies and procedures that were enforced in the kitchen should be followed such as having a thermometer in the freezer to monitor temperatures. Observation of the kitchen on 5/8/19 at 1:35 PM, revealed an open and undated 46-ounce bottle honey consistency tea in the first two (2)-door reach-in refrigerator near the kitchen entrance. Review of the manufacturer's instructions on the bottle indicated the tea should be discarded if not used within 10 days of opening. Interview with the CDM during this observation confirmed the staff had not labeled the bottle with an open date. Interview with the CDM on 5/8/19 at approximately 11:37 AM, revealed they did not have a drying rack for drying trays.	F 812	facility's Dietary Manager monthly for three (3) months and make recommendations and changes to ensure compliance.	

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F 812	Continued From page 13 Interview with the Housekeeping/Maintenance Supervisor on 5/9/19 at 8:50 AM, revealed he wrote a maintenance request on 12/20/18, for work that had to be done regarding the air conditioning ceiling vents in the kitchen. He reported that he had originally patched those identified areas around the air conditioning (a/c) ceiling vents himself last summer, and the contractor was going to come to work on it this summer of 2019. When asked if fixing the popcorn around the a/c ceiling vents in the kitchen was something he would normally patch up himself before the contractor came, he responded, "Yes."	F 812		

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	255291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2019**

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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 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		6/19/19

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

Electronically Signed | 06/14/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 321	Continued From page 1 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas as per NFPA 101 section 19.3.2.1.2. and NFPA 101 section 8.4.2 This deficiency affected three (3) of three (3) smoke compartments and all 55 residents in the facility on the day of survey. Findings include: During the building inspection on May 6, 2019 between 1:30 PM and 2:00 PM, observation revealed unsealed openings in the ceiling around the fire shutters in the all mechanical rooms of the facility. The mechanical rooms were not smoke tight and are incapable of resisting the passage of smoke throughout the facility. It was also observed the make up air for the gas hot water heaters was being taken from the attic.	K 321	1) On June 12, 2019, all unsealed openings in the ceiling around the fire shutters in all mechanical rooms of the facility were sealed by outside contractors. Make up air for the gas hot water heaters will be vented from outside air above the roof on June 19, 2019. Necessary materials have been ordered on June 13, 2019. 2) All residents have the ability to be affected by this deficient practice. 3) The Administrator in-serviced Maintenance Supervisor on June 12, 2019, on the importance of there being no unsealed openings in the ceiling around fire shutters in all mechanical rooms in the facility and the need to vent make up air for the gas hot water heaters from the outside and not from the attic. 4) The Administrator and/or Maintenance Supervisor will monitor for unsealed openings in the ceiling around the shutters in all mechanical rooms of the facility and monitor to assure make-up air for the gas hot water heaters is vented from outside the facility weekly for four weeks and monthly for three months. Any deficient practice found will be cleared immediately and brought to the Administrator for any necessary follow up actions. All findings will be brought to the Quality Assurance Committee quarterly.	

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K 321	Continued From page 2	K 321	5) All corrective actions will be completed by June 19, 2019.	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/7/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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