STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEADVILLE CONVALESCENT HOME	300 HWY 556/ROUTE 2 BOX 66 MEADVILLE, MS 39653

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 01/02/2019 to 01/04/2019. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F 656, F690, and F770. At the time of survey, the census was 54, and the facility 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	F 656		1/28/19

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

Electronically Signed | 01/28/2019

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 656	Continued From page 1 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 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, staff interview, facility policy review and record review, the failed to develop a care plan to address catheter care for Resident #26, and failed to follow the care plan related to catheter care for Resident #42; for two (2) of 16 resident care plans reviewed. Findings Include: Resident #26 A review of the facility's policy titled, "Total Care Plan Policy," undated, revealed it is the policy of this facility that the Interdisciplinary Care Plan will be done by the Interdisciplinary Team. The Care Plan will identify problems that affect the resident and his/ her care needs and identify the interventions related to the specific problems. A review of Resident 26's Care Plan, revealed a problem to address the diagnosis of Urinary	F 656	1. F656 Corrective action for resident #26 and resident #42 affected by this practice was accomplished by revising the resident's care plan on 01/04/2019 to include individual and detailed care of indwelling catheter. The Quality Assurance Nurse(QA)and the RN assessment nurse completed the care plans for both residents. 2. All residents with an indwelling catheter and/or requiring perineal care have the potential to be affected by the same practice. 3. All residents with orders for indwelling catheter will have individualized care plans for catheter care done by the RN Assessment nurse and/or Quality Assurance nurse. Resident #26 and #42 care plans were revised on 01/04/2019.	

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F 656	Continued From page 2 Retention and the use of a Foley Catheter, with an onset date of 11/16/2018. Resident #26's Care Plan did not indicate catheter care as an intervention. During an interview, on 01/04/2019 at 11:47 AM, with Licensed Practical Nurse (LPN) #2 /Minimum Data Set (MDS) Nurse, she confirmed the Care Plan for Resident #26 did not include catheter care as one of the interventions attributable to the resident having a catheter. During an interview, on 01/04/2019 at 2:00 PM, with the Director of Nursing (DON), she stated catheter care for Resident #26 should be included on the Care Plan as an intervention related to the resident having an indwelling Foley Catheter. The DON confirmed, the current Care Plan for Resident #26, did not have catheter care listed as an intervention. Review of the Face Sheet, revealed Resident # 26 was admitted by the facility, on 04/17/2015, with diagnoses to include Type Two (2) Diabetes and Chronic Obstructive Pulmonary Disease (COPD). Resident #42 A review of the facility's policy titled, "Catheter Care Policy", revealed it is the policy of this facility that catheter care will be done by the Licensed Practical Nurse (LPN) and/or Certified Nursing Assistant (CNA) during baths, every shift and as needed utilizing soap and water. The procedure included to: " 5. Cleanse the catheter from the body to the end of the catheter, never from the end of the catheter toward the body. 6. Do not	F 656	The care plans for the other residents with indwelling catheters was reviewed by the RN assessment nurse and Quality Assurance nurse on 01/07/2019 and 3 out of 3 were correct. An in-service for Interdisciplinary nurses(MDS,QA, RN Assessment/Infection Control Nurse, Medical Records Nurse, Treatment Nurse) was given on 01/07/2019 by the Director of Nursing, regarding care plans for indwelling catheters/perineal care. 4. The Infection Control nurse will keep a folder with all residents having an indwelling catheter. These residents care plans will be monitored on a monthly basis by Infection Control Nurse and report will be brought to all QA meetings to assure compliance. 5. This plan will be in place by January 28, 2019.	

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F 656	Continued From page 3 pull on the catheter." Review of the Comprehensive Care Plan for Resident #42, revealed a problem to address Foley Catheter required related to Urinary Retention. Interventions included: Change foley as ordered, catheter care every shift with soap and water, observe for signs and symptoms of urinary tract infections and report to Medical Director (MD), intake and output every shift, and change foley bag on the 29th of each month. During an interview and observation of catheter care, on 01/03/19 at 10:27 AM, Certified Nursing Assistant (CNA) #3 held the base of Resident 42's penis and used a soapy towel to clean the tubing by pulling outward. Resident #42 shouted, "ouch". CNA #3 took the rinse towel, held the base of Resident 42's penis and pulled outward. Resident #42 was asked by surveyor if that hurt him and he responded, "Yes". During an interview, on 01/03/19 at 12:07 PM, with Registered Nurse (RN) #1/Staff Development Nurse, revealed the CNAs are trained to secure the catheter at the tip of the penis near the meatus to prevent trauma and to prevent the catheter from coming out. RN #1 stated, the CNAs are checked off with demonstration on an actual resident. RN #1 confirmed, CNA# 3 failed to follow the facility's policy by not securing the catheter near the head of the penis. During an interview, on 01/03/19 at 12:16 PM, CNA #3 confirmed, he failed to secure the tubing at the tip of the penis near the meatus. CNA #3 stated, he held the base of the penis, so that he could keep the foreskin back. CNA #3 stated, he	F 656		

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F 656	Continued From page 4 did not realize why Resident #42 always said "ouch" during catheter care. A review of the facility's face sheet, revealed the facility admitted Resident #42, on (10/12/1918), with diagnoses which included, Urinary Retention, Congestive Heart Failure and Pulmonary Hypertension. A review of Resident #42's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2018, he had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		1/28/19

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F 690	Continued From page 5 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide catheter and incontinent/perineal care (peri-care) in a manner to prevent the possible spread of infection for Resident #26, and failed to provide catheter/peri-care in a manner to prevent possible trauma for Resident #42; for two (2) of four (4) incontinent care observations. Findings Include: A review of the facility's policy titled, "Catheter Care Policy," dated 06/23/2017, revealed to provide Peri-Care according to facility's policy. Procedure included: 4. Using a clean wash cloth or towel. A review of the facility's policy titled, "Incontinent Care Policy," dated 06/23/2017, revealed it is the policy of this facility that incontinent care will be conducted to insure that all incontinent care residents will receive appropriate treatment and services to prevent urinary tract infections. The procedure included to: 6. Cleanse the perineal	F 690	1.F690 Corrective action for the residents #26 and #42 affected by this practice was repeated on 01/03/2019 by the same Certified nurse assistants giving care and was observed and in-serviced by the Staff Development Nurse and Infection Control Nurse. The care was done correctly at this time. The Certified Nurse Assistants(CNA)involved in the care of this resident was given a One on One In-service by the Staff Development nurse and return demonstration was done correctly. Resident #26 and #42 were assessed by the RN Assessment/Infection Control nurse 01/02/2019 and 01/04/2019 and found to have no adverse effects from this practice. 2. All residents with indwelling catheters/perineal care have the potential to be affected by this practice.	

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F 690	Continued From page 6 area using a clean towel or bath cloth. Resident #26 During an observation of the catheter and incontinent (perineal) care for Resident #26, on 01/03/2019 at 11:45 AM, revealed Certified Nursing Assistant (CNA) #1, wiped the perineal area as well as the catheter tubing without ensuring a clean area of the wash cloth was used. While providing catheter care, CNA #1 wiped the catheter tubing, in a downward direction, twice with a clean area and then once with an unclean area of the wash cloth she was using. While providing perineal care, CNA #1 wiped the perineal area of Resident #26, twice with a clean area and twice with an unclean area of the wash cloth she was using. During an interview, on 01/04/2019 at 10:50 AM, with CNA #1, she stated that she did not fold the wash cloth, and could not determine the clean area from the dirty area when cleaning the perineal area. CNA #1 stated, she also could not determine the clean area from the dirty area during the catheter care. CNA #1 stated, she had been given an in-service and skills check-off every 6 (six) months. CNA #1 stated, that the facility's Staff Development Nurse (SDN) was the person that had done her in-services and check-off(s) for incontinent and catheter care. A review of the facility's document titled, "Procedure Checklist," dated 09/05/2018, revealed CNA #1 completed the skills check-off for providing perineal care. The skills check-off was observed and evaluated by the Staff Development Nurse (SDN)/Registered Nurse (RN) #1. The skills check-off form was signed by	F 690	3. On 01/04/2019 the Perineal/catheter care policy was revised to use separate cloths when doing perineal and catheter care to insure a clean cloth every time. The new policy also includes male catheter care to ensure the catheter is secured while doing care. The Perineal/Catheter Care Policy was reviewed by the Quality Assurance Committee and Medical Director on 01/10/2019 and approved as stated. The Staff Development Nurse gave In-Service to all Certified Nurse Assistants on 01/15/2019 and the new policy was reviewed with all licensed nursing staff. All new CNA's will be checked off upon hire by the Staff Development Nurse. All current CNA's will have quarterly check-offs on perineal/catheter care by the licensed nurse on shift. 4. The Staff Development Nurse will keep a record of all check-offs on perineal/catheter care and bring to the Quality Assurance Committee meetings on a quarterly basis to ensure this practice does not recur. The Staff Development Nurse will make a schedule of when certified nurse assistants are due to ensure all check offs are done in a timely manner. Check offs will occur on all shifts and be done by licensed nurses on that shift. The Staff Development Nurse and Infection Control Nurse will do intermittent perineal care observations on a monthly basis to ensure the new policy is being implemented.	

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F 690	Continued From page 7 CNA #1 and RN # 1. The form was checked "Pass" to indicate the procedure was completed with no problems. During an interview, on 01/04/2019 at 11:00, with RN #1/SDN, she revealed that all of the CNA staff is given incontinent and catheter care in-services every 6 (six) months. RN #1 stated, the CNA staff is provided individual incontinent and catheter care skills check-offs as well. RN #1 revealed, she reads from a list of skills and see if the CNAs can tell her how they do it. RN #1 stated, using one wash cloth and wiping the perineal area or the catheter tubing without determining where the clean or dirty area is, is not the correct way to do perineal or catheter care. During an interview, on 01/04/2019 at 11:47 AM, with Licensed Practical Nurse (LPN) #2 /Minimum Data Set (MDS) Nurse, she revealed that the SDN for the facility is the person who provides the skills check-off and the in-services for catheter care. LPN #2 stated, that the expectation would be that the nursing staff would perform the catheter care, and do it according to the training and the in-services they have participated in. During an interview, on 01/04/2019 at 2:00 PM, with the Director of Nursing (DON), she confirmed that the way in which CNA #1 performed the catheter and incontinent care, with her not ensuring that there was a clean area when wiping, was certainly incorrect. Review of the Face Sheet, revealed Resident # 26 was admitted by the facility, on 04/17/2015, with diagnoses to include Type Two (2) Diabetes and Chronic Obstructive Pulmonary Disease (COPD).	F 690	5. This plan of correction will be completed by January 28, 2018.	

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F 690	Continued From page 8 Resident #42 A review of the facility's policy titled, "Catheter Care Policy", revealed it is the policy of this facility that catheter care will be done by the Licensed Practical Nurse (LPN) and/or Certified Nursing Assistant (CNA) during baths, every shift and as needed utilizing soap and water. The procedure included to: " 5. Cleanse the catheter from the body to the end of the catheter, never from the end of the catheter toward the body. 6. Do not pull on the catheter." Review of the Comprehensive Care Plan for Resident #42, revealed a problem to address Foley Catheter required related to Urinary Retention. Interventions included: Change foley as ordered, catheter care every shift with soap and water, observe for signs and symptoms of urinary tract infections and report to Medical Director (MD), intake and output every shift, and change foley bag on the 29th of each month. During an interview and observation of catheter care, on 01/03/19 at 10:27 AM, Certified Nursing Assistant (CNA) #3 held the base of Resident 42's penis and used a soapy towel to clean the tubing by pulling outward. Resident #42 shouted, "ouch". CNA #3 took the rinse towel, held the base of Resident 42's penis and pulled outward. Resident #42 was asked by surveyor if that hurt him and he responded, "Yes". During an interview, on 01/03/19 at 12:07 PM, with Registered Nurse (RN) #1/Staff Development Nurse, revealed the CNAs are trained to secure the catheter at the tip of the penis near the meatus to prevent trauma and to prevent the catheter from coming out. RN #1	F 690		

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F 690	Continued From page 9 stated, the CNAs are checked off with demonstration on an actual resident. RN #1 confirmed, CNA# 3 failed to follow the facility's policy by not securing the catheter near the head of the penis. During an interview, on 01/03/19 at 12:16 PM, CNA #3 confirmed, he failed to secure the tubing at the tip of the penis near the meatus. CNA #3 stated, he held the base of the penis, so that he could keep the foreskin back. CNA #3 questioned the surveyor whether he should have held the penis somewhere else. CNA #3 revealed, that the resident always said "ouch". CNA #3 stated, he did not realize why Resident #42 always said "ouch" during catheter care. During an interview, on 01/04/19 at 01:24 PM, with the Director of Nursing (DON), she confirmed CNA #3 failed to prevent possible trauma to the meatus by not securing the tip of the penis while providing catheter care. A review of the facility's face sheet, revealed the facility admitted Resident #42, on (10/12/1918), with diagnoses which included, Urinary Retention, Congestive Heart Failure and Pulmonary Hypertension. A review of Resident #42's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2018, he had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition.	F 690		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services.	F 770		1/28/19

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F 770	Continued From page 10 §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure that Culture and Sensitivity (C&S) Laboratory (Lab) results were obtained in a timely manner for one (1) of four (4) resident C&S Lab results reviewed: Resident #25 Findings include: A review of a document on the facility's letterhead, unsigned, untitled, and dated January 04, 2019, revealed it is the policy of the facility is that all Lab orders with Culture and Sensitivity reports be followed by the Infection Control Nurse or the Quality Assurance (QA) Nurse on a daily basis. The Infection Control or the QA Nurse will follow through to ensure that all reports are completed in a timely manner. A review of the "Physicians Telephone Orders" for Resident #25, revealed an order written and dated on 10/08/2018 to obtain a Culture and Sensitivity (C&S) Lab test of the drainage from Resident #25's left and right eye. A review of the facility's Lab requisition orders, revealed a requisition was completed on 10/08/2018 for a C&S of the drainage to the left and right eyes of Resident #25.	F 770	1. F770 The resident #25 affected by this practice was being followed by her primary care provider for the care of her eye. The resident was seen in the facility by the primary care provider and orders were given on 10/19/2018 for Antibiotic eye drops due to drainage noted to eye and residents husband request. The provider did not have a culture result at this time. A repeat culture and sensitivity was obtained on 12/18/2018 and the primary care provider repeated the same medication and added another antibiotic eye drop. The resident was seen again by the primary care provider on 01/07/2019. Another culture was obtained by provider and after results were obtained the medications were discontinued. All orders/labs on resident #25 were reviewed by the Quality Assurance Nurse on 01/07/2019 and found to be followed up by the provider and resolved. 2. All residents have the potential to be affected by this practice. 3. A new Lab Policy was implemented on 01/04/2019 for the Quality Assurance	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 11 During an interview, on 01/04/2019 at 1:58 PM, with Licensed Practical Nurse (LPN) #3 / Infection Control Nurse, she confirmed that a C&S Lab of both eyes for Resident #25 had been ordered, but the facility failed obtain the results of that Lab in a timely manner. LPN #3 stated, that the C&S had been re-ordered in December, and that the results were obtained. LPN #3 stated, Resident # 25's physician was aware. During an interview, on 01/04/2019 at 2:00 PM, with the Director of Nursing (DON), she confirmed the results from the C&S Lab order on 10/08/2018, for Resident #25, had not been received. The DON stated, "They dropped the ball and did not obtain results." Review of the Face Sheet revealed, Resident #25 was admitted by the facility, on 04/17/2015, with diagnoses to include Type Two (2) Diabetes and Essential Hypertension.	F 770	Nurse and the Infection Control Nurse to review all orders and labs on a daily basis to ensure results are obtained and sent to the physician giving the order. All nurses were in-serviced on the new Lab Policy by the Director of Nursing on 01/08/2019. The Lab Policy was brought to the Quality Assurance meeting on 01/10/2019 and approved by the QA committee and the Medical Director. 4. A new lab binder was put in place with Quality Assurance and Infection Control to track the labs and the results. The binders will be brought to all Quality Assurance meetings for review by the committee to ensure this practice does not recur. 5. This plan of action will be implemented by January 28, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2019**

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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 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 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	K 918		1/28/19

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

Electronically Signed | 01/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2019**

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K 918	Continued From page 1 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 inspect and do preventive maintenance of the generator as directed by NFPA 99 sections 6.4., 6.4.2 and 6.4.2.2.3. Based on further observation while testing, the facility did not maintain the generator's Life Safety Branch in accordance to NFPA 99. Both standard deficiencies practiced affected portions of the facility on the day survey. These deficient practices have the potential of affecting three (3) of five (5) smoke compartments on the day of facility survey. Findings include: While testing the generator on 1-9-19 at 10:25 AM, observation revealed the generator failed to transfer power to all 'Life Safety Branch' required portions of the facility. The generator failed to power all emergency lighting, emergency power plugs and illuminated exit sign in the facility. The 35KW diesel fueled generator did cover the minimum standards requirements and Life Safety portions of the facility. There were operating standard plugs and standard lighting in theses portions of the building. On 1-9-19 at 11:30 AM, interview with the Maintenance Director revealed an electrical issue was created because the refrigerator and freezer	K 918	1. Corrective action was accomplished for this practice by the Maintenance Supervisor calling the electric repair company for our facility, Case Air. On 01/14/2019, the generator as well as all systems connected to it were checked. The main disconnect switch on the generator was found to be in the off position. Once this was engaged, all emergency systems went back to normal function. Natchez Electric did a preventive maintenance check on the generator on 01/22/2019.Copies of these reports are attached. 2. All residents have the potential to be affected by this practice. 3. The Maintenance Supervisor will check the generator for normal operation every Monday. With this check he will also check to see that all switches are in functioning position. The emergency systems that are run by the generator will be checked on a monthly basis for proper functioning. 4. The Maintenance supervisor will maintain logs for these weekly and monthly checks and bring them to the Quality Assurance meetings for approval	

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K 918	Continued From page 2 placed on emergency power branch of the generator. The Maintenance Director contacted Natchez Electric, who performs all their maintenance of the electrical system for the facility, and it was revealed the generator housing circuit breaker was in the off position. The findings were acknowledged by the Administrator and the Maintenance Director verified this observation during the exit interview on 1-9-19.	K 918	by the Quality Assurance Committee. 5.This corrective action will be completed by January 28,2019.	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 1/9/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 01/28/2019

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.