STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255104	A. BUILDING _____ B. WING _____	03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA LIVING CENTER	1950 GRANDVIEW DRIVE GRENADA, MS 38901

(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 3/27/18 to 3/30/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F644. At the time of the survey, the census was 99, and the facility held a license for 110 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of of the facility's policy and procedure, the facility failed to ensure the Level II screening occurred prior to admission; and, whenever the resident	F 644	The Social Services Director along with the Admissions Nurse submitted the change in status request form for resident #45 to the State contracted agency to	5/7/18

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F 644	Continued From page 1 has a significant change in status. Findings include: Record review of Resident # 45's chart revealed a new diagnosis of Psychosis was documented due to the resident's behavior and new order for Haldol on 4/14/17. Review of the PASARR performed on admission revealed no Level II was required on admission and was not performed when the new diagnosis was documented. The facility did not notify the State Mental Health Department of the change in condition or the new diagnosis. On 3/29/18 at 06:03 PM, an interview with the Director of Nursing (DON) confirmed no one realized a Level II should be performed for Resident #45 after the new diagnosis of Psychosis was documented. The DON stated the facility would assign the Social Services and Minimum Data Set nurses to monitor any significant change and new diagnosis and then notify the appropriate state department for a potential Level II.	F 644	initiate the Level II process on 3/29/2018. The Level II was reviewed by an Independent Contractor, an Independent Quality Reviewer, and a Department of Mental Health Summary Reviewer. The Level II was completed for resident #45 on 4/5/2018 by the State Mental Health Authority. 71 of 99 residents were identified to have diagnosis, medications, and/or psychological therapy that would indicate the need for a Level II and at risk of the deficient practice. 51 of the 71 residents identified have been excluded for the need of a Level II. The remaining 20 residents of the 71 identified required and had a Level II completed. An inservice was completed on 4/5/2018 by the Director of Nursing on the policy/procedure related to PASRR and Level II titled Pre-Admission Screening PAS/PASRR (MS Only) with a revision date of 11/17 with 1 of 1 Social Services Director, 1 of 1 Admissions Nurse, 1 of 1 Nurse Case Manager, and 2 of 2 Minimum Data Set Nurses. The Quality Assurance Committee reviewed the policy titled Pre-Admission Screening PAS/PASRR (MS Only) with revision date 11/17 with no recommended changes on 4/17/2018. Admissions and Minimum Data Sets will be audited by the Director of Nursing,	

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F 644	Continued From page 2	F 644	Nurse Case Manager, and/or Administrator to ensure compliance with facility policy/procedure related to Level II weekly for four weeks and monthly for two months and findings recorded on the transmission meeting report form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the audits completed by the Director of Nursing, Nurse Case Manager, and/or Administrator monthly for three months. The corrective action will be completed by 5/7/2018.	

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	255104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/29/2018**

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GRENADA LIVING CENTER	**1950 GRANDVIEW DRIVE** **GRENADA, MS 38901**

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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 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide a supervised automatic sprinkler system with complete coverage for all portions of the building as required by NFPA 101 chapter 19.3.5.1. This deficiency affected one (1) of five (5) smoke compartments and 21 of 99 residents in the facility on the day of survey.	K 351	Quotes obtained to install an additional fire sprinkler head in the HVAC closet in the therapy department as required by NFPA 101 chapter 19.3.5.1 LSC standard. This will be completed by 5/7/18 1 of 5 smoke compartments and 21 of 99	5/7/18

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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 351	Continued From page 1 Findings include: On March 29, 5018 at 10:25 AM, observation revealed no sprinkler head and no fire sprinkler protection in the HVAC Closet of the Therapy Room. The facility was made aware of the deficiency during the exit conference.	K 351	residents have the potential to be affected by this alleged deficient practice. In-service was provided by administrator on March 30th 2018 to maintenance director concerning any remodels or additions that might require additional sprinkler coverage. Any closets or offices that may be added or remodeled in the building in the future will be checked by the maintenance supervisor or administrator to ensure the area will be covered/protected by fire sprinkler per LSC standards. Findings from audits and inspections will be monitored by Quality Improvement Committee and reviewed in Quality Assurance committee meeting quarterly till resolved. The corrected action will be completed by 5/7/2018	

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E 000	Initial Comments Survey conducted on 3/29/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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