STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255210	A. BUILDING _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 from 2/10/2020 through 2/13/2020. The State Agency determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited deficiencies at F641 and F842. At the time of survey, the facility had a census of 56, and was licensed for 60 beds.	F 000		
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 observation, record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to Respiratory Care, for one (1) of 20 MDS assessments reviewed, Resident #21. Findings include: Review of the facility's "Comprehensive Assessment and Re-Assessment" policy, revealed the assessment of the care or treatment required to meet the needs of the resident shall be ongoing throughout the resident's facility stay, with the assessment process individualized to meet the needs of the resident population. The Registered Nurse (RN) Resident Assessment Coordinator, using the quarterly review instrument specified by the state, must assess each resident no less frequently than every three (3) months.	F 641	On February 14, 2020 Resident #21 Respiratory Evaluation was completed by the Minimum Data Set Licensed Practical Nurse The facility has determined that all residents that require oxygen therapy have the potential to be affected. An in-service was conducted on February 13, 2020 by the Director of Nursing Service with the Minimum Data Set Licensed Practical Nurses addressing the importance of accurately coding Section O of the MDS and completing a Respiratory Evaluation quarterly for each resident that requires oxygen therapy. The Director of Nursing will review section O for two residents per week starting on	4/10/20

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

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F 641	Continued From page 1 "Each healthcare professional who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment relative to the resident's condition and discharge or entry status." A record review of Resident #21's Quarterly MDS assessments, with an Assessment Reference Date (ARD) of 8/21/2019 and 11/18/2019, revealed, Section O100 (Special Treatments and Programs), was left unchecked for oxygen therapy while a resident in the facility. Record review of Resident #21's Medication Administration Record (MAR), dated November 2019, revealed the resident received Oxygen at two (2) liters per minute via nasal cannula, ordered as of 5/21/2015. Review of Resident #21's Care Plan revealed, a problem to address use of required Oxygen at 2 liters per nasal cannula related to Respiratory Failure, with an onset date of 3/06/2019. On 2/11/2020 at 11:34 AM, during an observation, Resident #21 was noted wearing Oxygen per nasal cannula and running at 2 liters per concentrator. During an interview, on 02/12/2020 at 10:18 AM, Licensed Practical Nurse (LPN) #1/MDS Care Plan Nurse confirmed Resident #21 was on continuous Oxygen at 2 liters per minute via nasal cannula. LPN #1 revealed Resident #21 quarterly assessments were suppose to indicate oxygen therapy, but the documentation in the nurses notes did not support the look back period. LPN #1 confirmed Resident #21's Medication Administration Record (MAR) for	F 641	April 1, 2020 that require a respiratory evaluation for six consecutive weeks to ensure accuracy of coding. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 641	Continued From page 2 November did have oxygen listed and was signed off by the nurses. LPN #1 confirmed the MDS assessment should match the resident's current status, which would include oxygen, therefore, the MDS was not correct.	F 641		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		4/10/20

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F 842	Continued From page 3 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to accurately document a physician's order as prescribed, for one (1) of 20 resident records	F 842	On February 12, 2020 The medical records Licensed Practical Nurse updated Resident #24 Medication Administration Record.	

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F 842	Continued From page 4 reviewed, Resident #24. Findings include: Review of the facility's "Medical Record, Medication, Discharge, Verbal and Written Orders" policy, with a revision date of 11/28/2017, revealed, medical records of residents shall be maintained according to regulations and laws regarding proper documentation and privacy. A review of Resident #24's physician orders, dated 12/05/2019, revealed an order was written to discontinue Celexa 20 milligrams (mg) daily, and start Celexa 10 mg daily for Depression. Review of the "Note to Attending Physician/Prescriber", dated 12/05/2019, revealed the physician signed to reduce Resident #24's dosage of Celexa 20 mg daily to Celexa to 10 mg daily. Review of Resident #24's printed "Physician Orders" for February 2020, revealed an order for Celexa 20 mg daily, with a start date of 12/05/2019. On 02/12/2020 at 3:30 PM, during an interview, the Director of Nursing (DON) revealed the current physician orders for Resident #24 should match the MAR and medication card to ensure the resident was receiving the right medication and right dosage. The DON revealed Resident #24's current physician orders should have been changed to reflect the right dosage. On 02/12/2020 at 3:50 PM, during an observation and interview with Licensed Practical	F 842	On February 28, 2020 all Physician orders were compared to each residents medication administration record by the Interdisciplinary Team. All residents have the potential to be affected. On February 13, 2020 through March 5, 2020 nurses were in serviced by the Director of Nursing on receiving and reviewing the manifestation sheet from the pharmacy and comparing the medication card label to the physician orders, then to the medication administration record. The Medical Records Licensed Practical Nurse will audit new orders by comparing the physician orders to the Medication Administration Record for four residents weekly for six consecutive weeks to ensure compliance starting on March 30, 2020. Discrepancies will be promptly reported to the Director of Nursing. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 842	Continued From page 5 Nurse (LPN) #4, revealed Resident #24's medication card and Medication Administration Record (MAR) documented Celexa 10 mg. LPN #4 revealed the resident was currently receiving Celexa 10 mg.	F 842		

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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 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to properly ensure the operability of the sprinkler system as required by NFPA 25 table 2-1 and NFPA 25 section 2-2.6. This deficiency practice affected all residents in the facility at the time of survey.	K 353	Statements contained herein are intended for the purpose of compliance with Federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third	4/2/20

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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 353	Continued From page 1 Findings includes: During document review on 2/12/2020 at 11:05 AM, the facility could not provide documentation showing the quarterly inspection of the sprinkler system during the 4th quarter of 2019 (October, November, and December of 2019).	K 353	party. It is solely for purposes of compliance with participation requirements of Medicare and Medicaid. The sprinkler system inspection was conducted on February 3, 2020, by Southeastern Automatic Sprinkler. The sprinkler company did not provide the report until after the survey was conducted. Due to the lack of documentation of the testing the sprinkler system, any and all residents has the potential to be affected by this deficient practice. The Administrator conducted a One on One with the Maintenance Director on February 17,2020. The topic of the in-service was, The Importance of Documentation of Quarterly Sprinkler Testing as per NFPA 25, 9.7.5, 9.7.8. Sprinkler system testing is on the facility TELs program to be completed by the Maintenance Director or Designee. The documentation will be placed in the Life Safety Binder. Thereafter, the Administrator or his designee will randomly audit the sprinkler system documentation to ensure compliance. Any concerns regarding the sprinkler system will be discussed in QAPI for areas of improvement and/or change. Compliance will be met on or before April 10,2020.	

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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, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. The deficient practice affected the entire facility on day of survey. Findings includes: During document review on 2/12/2020 at 11:10 AM, the facility could not provide documentation showing the fire drills being conducted during the 4th quarter of 2019 (October, November, and December of 2019).	K 712	Statements contained herein are intended for the purpose of compliance with Federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of compliance with participation requirements of Medicare and Medicaid. Fire Drills will be conducted at least quarterly on each shift at varying times. For example, fire drills were conducted in January 21, February 17, and March 27 of 2020. As the lack of documentation regarding the facility□ fire drills has the potential to affect any and all residents, the Administrator conducted a One on One	4/2/20

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K 712	Continued From page 3	K 712	in-service with the Maintenance Director and maintenance staff on February 17, 2020. The topics of the in-service was The Importance of facility fire drills as per NFPA 101 section 19.7.1.2. On February 17, 2020 a meeting was held by the Administrator. Those in attendance were the Staff Educator Nurse, the Maintenance Director and maintenance staff. At the conclusion of the meeting the following systemic changes were implemented. A. The Administrator and Maintenance Director will meet at the beginning of each month and utilizing calendars, fire drills will be planned and recorded for scheduling for the month and correct rotation of shift fire drills will be planned. B. The Staff Educator will verify the scheduling of the fire drills no later than the end of the first full week of the month and verify the correct rotation of shift fire drills. The Fire Drills will be reported in QAPI monthly x's x 4. Thereafter, the Administrator or his designee will randomly audit the fire drills to ensure compliance. Any concerns regarding the fire drills will be discussed in QAPI for areas of improvement and/or change. All documentation will be kept in the Life Safety Binder. Compliance will be met on or before April	

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K 712	Continued From page 4	K 712	10,2020.	
K 918 SS=D	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 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)	K 918		4/2/20

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K 918	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. The deficient practice affected the entire facility on day of survey. Findings include: During document review on 2/12/2020 at 11:15 AM, the facility could not provide documentation showing the weekly inspections and monthly load tests for the generator for the months October, November, and December of 2019.	K 918	Statements contained herein are intended for the purpose of compliance with Federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of compliance with participation requirements of Medicare and Medicaid. Generator testing and documentation monthly and weekly was completed by the Maintenance Director and team on February 17, 2020. Weekly and monthly inspections were completed timely for the months of February and March and will continue as required per 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA111, 700.10 (NFPA 70). The load bank test was completed on February 3, 2020 by Taylor Power Systems. All residents have the potential to be affected by this deficient practice. On February 17, 2020 the Administrator in-serviced the Maintenance Director and maintenance team. The topic of the in-service was The Importance of Generator weekly testing and monthly load testing as per 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA111, 700.10 (NFPA 70). Generator inspections are on the facility TELS program as a weekly and monthly task to be completed by the	

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K 918	Continued From page 6	K 918	Maintenance Director or Designee. The documentation will be placed in the Life Safety Binder. Compliance will be monitored by performing audits of the generator inspections weekly x 4, monthly x 2, and quarterly x 2 by the Maintenance Director and/or Administrator. Audit results will be forwarded to the QAPI committee for additional monitoring or modification. Compliance will be met on or before April 10,2020.	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/12/20 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 | 04/02/2020

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.