STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(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 06/07/2018 to 06/13/2018. During the survey, The SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA cited the regulatory deficiencies F641,F 656, F679, and F690. At the time of the survey, the facility census was 43, with a license 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 record review, staff interview, and facility policy review, facility failed to accurately code the Minimum Data Set (MDS) for one (1) of 14 MDS assessment reviewed. Resident #15 Findings include: A review of the facility's policy entitled, "Resident Assessment Using the MDS" (Minimum Data Set) undated, revealed: Every resident will be assessed using the MDS according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. Each person completing a section of the MDS attests to its accuracy by affixing his/her signature to that section. A review of the MDS manual, dated October	F 641	This plan of correction serves as Sunplex Subacute Center's allegation of substantial compliance as of 7/6/18. This plan of correction does not constitute an admission or agreement by the provider, Sunplex Subacute Center, of the truth of the facts alleged or conclusion set forth in this Statement of Deficiencies. This plan of correction has been respectfully developed solely because it is required by State and Federal Law. 1. The Minimum Data Set for Resident #15 section H was corrected and resubmitted by the Minimum Data Set	7/6/18

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

Electronically Signed | 07/03/2018

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F 641	Continued From page 1 2017, under Section H (Bladder and Bowel) revealed: Coding instructions for H0400 as follows: to code "9"- Not rated, resident had an ostomy or did not have a bowel movement for the entire seven (7) days. Resident #15 Record review of the comprehensive MDS assessment for Resident #15, with an ARD of 11/2/17, revealed section H0400 was coded "9" or not rated, indicating the resident had an ostomy or had not had a bowel movement (BM) in the past seven (7) days. Review of the BM record for the lookback period for the 11/2/17 MDS revealed Resident #15 had BMs five (5) of the seven (7) days. Observation on 06/11/18 at 11:05 AM, revealed Certified Nursing Assistants (CNAs) #1 and #2 performed incontinent/catheter care for Resident #15 and the resident did not have a colostomy. On 6/12/18 at 4:05 PM, interview with Licensed Practical Nurse (LPN) #1 revealed she had coded section H0400-bowel continence in error, for Resident #15's MDS with ARD of 11/2/17. She also stated the resident had not had a colostomy and by coding "not rated" meant the resident has a colostomy. A review of the facility's Face Sheet revealed Resident #15 was admitted on 8/18/17, with a diagnosis of Neurogenic Bladder.	F 641	Coordinator as of 6/28/18. 2. The center recognizes that all residents could have the potential to be affected by the same deficient practice. The Minimum Data Set Coordinator, Licensed Practical Nurse #1, audited 100% of current resident's Minimum Data Sets' section "H", ensuring all have been properly coded and correct as of 6/28/18. 3. The Director of Nursing, a Registered Nurse, in-serviced both Minimum Data Set Coordinators (Licensed Practical Nurse #1 and #2) on 6/12/18, on properly coding the Minimum Data Set section H. The Director of Nursing will audit all new weekly Minimum Data Sets, section H for 2 weeks to ensure proper coding of section H, then audit 2 Minimum Data Sets per week for 6 weeks to ensure proper coding of section H. 4. The results of the audits will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, for review and recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the Medical Director, Director of Nursing, Nursing Home Administrator and two additional member from the Social Services Director, Maintenance Director, Minimum Data Set Coordinator, Medical Records, Nurses, Certified Nursing Assistants, and Life Connections Coordinator.	

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F 656	Continued From page 2	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its 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	F 656		7/6/18

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F 656	Continued From page 3 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, record review, staff interview and facility policy review, the facility failed to develop and/or implement the plan of care for two (2) of 14 care plans reviewed, related to: a) incontinent care and catheter care for Resident #15 and one on one (1:1) activities for Resident #31 Findings include: A review of the facility's policy entitled, "Using the Care Plan", undated, revealed daily care and documentation should be consistent with the resident's care plan. Resident # 15 Record review of Resident # 15's care plan for activities of daily living (ADL) initiated on 1/3/16, and revised on 11/3/17, revealed toilet use extensive times two (2) for assistance. The skin impairment care plan initiated on 1/13/16, and revised on 12/20/17, revealed to keep skin clean and dry. The care plan for Foley catheter revealed: Foley catheter to drainage bag and catheter care every shift. The care plan did not address proper incontinent care or the use of a securing device. On 06/11/18 at 11:05 AM, incontinent care was observed on resident #15, performed by Certified Nursing Assistants (CNAs) #1 and #2. During incontinent care, after positioning the resident	F 656	1. The care plan for Resident #15 was updated by the Minimum Data Set Coordinator to address proper incontinence care, use of a catheter securing device, and locating the catheter bag while positioning a resident during care as of 6/29/18 Resident #31's care plan was updated by the Life Connections Coordinator to include 1:1 in room activities on a regular basis as of 7/2/18. 2. The center recognizes that all residents with catheters, incontinence needs, and needing in-room activities could have the potential to be affected by the same deficient practice. The Minimum Data Set Coordinator, Licensed Practical Nurse #1, has audited all 3 care plans for those with catheters to ensure the care plan includes proper incontinence care and the use of a securing device as of 7/2/18. The Life Connections Coordinator has reviewed all residents to ensure those needing 1:1 in-room activities were addressed in the care plan including interventions and being done on a routine basis, finding that 5 residents are in need of 1:1 in-room routine activities, having care plans and activities in place as of 7/2/18. 3. The Minimum Data Set Coordinators,	

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F 656	Continued From page 4 onto her right side, CNA #1 wiped the resident from her back downward towards the front of her body. Resident # 15 did not have her catheter tubing secured to her leg while incontinent care and catheter care was being performed. During incontinent care, CNAs #1 and #2 positioned Resident #15 onto her right side and left the catheter drainage bag hanging on the opposite side of the bed. On 6/12/18 at 4:05 PM, interview with Licensed Practical Nurse (LPN) #1 revealed she would expect the staff to follow the resident's comprehensive care plan. A review of the facility's Face Sheet reveals the resident was admitted on 8/18/17, with a diagnosis of Neurogenic Bladder. Resident #31 Review of Resident #31's plan of care, initiated 6/9/17, revealed a potential for decreased activities due to limited mobility. Interventions included Western Movies, resident would like to be visited by the Chaplin or spiritual care volunteer, and shopping outings. There were no interventions for routine activity staff interaction on a regular basis or room activity. Review of Resident #31's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/18, revealed a Brief Interview Status (BIMS) score of 13, which indicated no cognitive impairment. A review of the facilities Activity Participation Record revealed Resident #31 enjoyed activities in her room. The record also reveal Resident #31	F 656	Licensed Practical Nurse #1 and #2, and Life Connections Coordinator were in-serviced by the Director of Nursing, a Registered Nurse, as of 7/2/18 on proper care planning for those with catheter care, those with incontinence, and those needing 1:1 in-room activities. The Director of Nursing will audit 4 care plans a week for four weeks and then 2 random care plans a week for 4 weeks for those with catheters and/or those with incontinence needs to ensure care plans are correct. Minimum Data Set Licensed Practical Nurse #1 will audit all residents needing 1:1 in-room activities on a weekly basis for 4 weeks, then every other week for 4 weeks for those needing 1:1 in room activities are in-place for those needs of those residents. 4. The results of the audits will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing and Minimum Data Set Licensed Practical Nurse #1, for review and recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the Medical Director, Director of Nursing, Nursing Home Administrator and two additional member from the Social Services Director, Maintenance Director, Minimum Data Set Coordinator, Medical Records, Nurses, Certified Nursing Assistants, and Life Connections Coordinator.	

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F 656	Continued From page 5 recieved (1:1) activity therapy three (3) times for the month of June. On 06/7/18 at 11:06 AM, observation Resident #31 revealed the resident laying in bed with the head of bed elevated, and television off. Observation on 06/7/18 at 1:08 PM, revealed Resident #31 laying in bed with the television off. The resident's Sister was in the room visiting. Resident #31's Sister stated that the facility staff doesn't come in the room and provide activities such as reading or even talking to the resident. Observation 06/7/18 at 2:10 PM, revealed Resident #31 laying in bed with the television on. Interview with the resident revealed no activity people had been in her room, only the Nurse's and CNA's On 6/7/18 at 3:20 PM, observation revealed the resident laying in bed. The resident continues to say no activity person was in the room. On 6/11/18 at 10:00 AM, Observation revealed Resident #31 laying in bed with the television on; the resident stated no activity person came in the room. On 06/11/18 at 1:34 PM, 6/11/18 at 3:42 PM, 6/12/18 at 9:48 AM, and 6/12/18 at 1:51 PM, observation and interview revealed Resident #31 laying in bed with complaint of no activities and/or no activity person present. During an interview on 6/13/18 at 10:53 AM, a LPN #2 stated that the resident complains of no activity and said that she goes into the resident's room and spends time with her whenever she	F 656		

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F 656	Continued From page 6 can. The Nurse said she will bring it to the Activity Directors attention that the resident needs one on one (1:1) activities. Interview with Resident #31 on 6/13/18 at 1:15 PM, revealed a complaint of no activity. On 6/13/18 at 1:20 PM, interview with the Administstrator revealed that the Activity Department should be doing 1:1 activities with Resident #31. The Administrator stated that several CNA's are trained to replace the Activity Director when she's not at the facility. On 6/13/18 at 2:19 PM, interview with the Activity Aide, revealed this was her first week in activities. She stated that she had not done activity with Resident #31 until today and she gave her a manicure this afternoon, after the surveyor talked to the Nurse.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, resident interview, and facility policy	F 679	1. 1:1 in-room activities for Resident #31 was restarted as of 6/13/18. The Life	7/6/18

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F 679	Continued From page 7 review, the facility failed to provide one on one (1:1) activities for one (1) of five (5) residents observed for activities. Resident #31 Findings include: Resident #31 A review of the facility Activity policy titled, "Individual Activities and Room Visits Program", dated 4/26/2010, revealed an individual activities will be provided for those residents whose situations or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. Residents who are able to maintain an independent program will have supplies available to them. A review of the facilities Activity Participation Record revealed Resident #31 enjoyed activities in her room. The record also reveal Resident #31 received (1:1) activity therapy three (3) times for the month of June. A review of the Minimum Data Set (MDS) dated 5/19/18, of the Preference for Customary Routine and Activities (section F), revealed Resident #31 preferred to have books, magazines and news papers read. Resident #31 also enjoyed listening to music and doing things with groups of people. A review of Resident #31's Comprehensive MDS assessment with an ARD date 5/19/18, revealed Resident #31's Brief Interview Mental Status (BIMS) score is 13, which indicated Resident #31 is cognitively intact. Observation on 06/7/18 at 11:06 AM, revealed Resident #31 laying in bed with the head of bed	F 679	Connections Staff was in-service by the Nursing Home Administrator as of 7/2/18 on providing 1:1 in-room activities for those needing them on a routine basis and how to document the activities. 2. The center recognizes that all residents could have the potential to be affected by the same deficient practice. The Life Connections Coordinator audited as of 7/2/18 all current residents for the need of 1:1 group activities and identified 5 residents in need of routine 1:1 in room activities. The Life Connections Coordinator ensured that the five residents needing 1:1 in room activities had these services in-place, to include documentation of the services, as of 7/2/18. 3. All Life Connections Staff were in-serviced by the Nursing Home Administrator as of 7/2/18 on providing 1:1 in-room activities for those needing them on a routine basis and how to document the activities. The Nursing Home Administrator will audit all current residents on 1:1 in-room activities residents on a weekly basis for 4 weeks, then every other week for 4 weeks to ensure those who are in need of in-room 1:1 activities are receiving these services and that it is being properly documented. 4. The results of the audits will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Nursing Home Administrator, for review and	

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F 679	Continued From page 8 elevated and television turned off. Resident #31 is blind, speech is clear and able to make needs known. During an Interview with Resident #31 on 6/7/18 at 11:06 AM, she stated that the activity department had not come to her room for a month. Resident #31 said she enjoyed having company and talking to people. Resident #31 also said she enjoyed manicures. Resident #31 stated she wished somebody would read the paper to her. Observation on 06/7/2017 at 1:08 PM, revealed Resident #31 laying in bed, the television is off, and her Sister visiting. The Sister stated that the facility staff didn't come in the room and provide activities such as reading or even talking, except for the Nurse's and CNA's. Observation and interview with Resident #31 on 6/7/18 at 2:10 PM, 6/7/18 at 2:10 PM, 6/7/18 at 3:20 PM, 6/11/18 at 10:00 AM, 06/11/18 at 1:34 PM, 6/11/18 at 3:42 PM, 6/12/18 at 9:48 AM, 6/12/18 at 1:51 PM, 6/13/18 at 10:53 AM, and 6/13/18 at 1:15 PM revealed the resident continued in her room with complaint of not having activity or activity personnel come to her room. Interview with Licensed Practical Nurse (LPN) #2 on 6/13/18 at 10:53 AM, revealed that she goes into the Resident #31's room and spends time with her whenever she can. LPN #2 said she will bring it to the Activity Director's attention that the resident needs more one on one activities. Interview on 6/13/18 at 1:20 PM, with the Administrator(ADM), revealed the Activity	F 679	recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the Medical Director, Director of Nursing, Nursing Home Administrator and two additional member from the Social Services Director, Maintenance Director, Minimum Data Set Coordinator, Medical Records, Nurses, Certified Nursing Assistants, and Life Connections Coordinator.	

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F 679	Continued From page 9 Department should be doing one on one activities with Resident #31. The Administrator stated that several CNA's are trained to replace the Activity Director when she's not at the facility. The Activity Director is out because her sister died yesterday. Interview on 06/13/18 at 2:19 PM, with Activity Aide #1, revealed this was her first week in activities. The Activity Aide #1 confirmed she did not do activities with Resident #31 until today. The Activity Aide #1 gave Resident #1 a manicure this afternoon, after the surveyor talked to the nurse.	F 679		
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; and	F 690		7/6/18

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F 690	Continued From page 10 (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, staff interview, and facility policy review, the facility failed to provide incontinent/catheter care in a manner to prevent the possible spread of infection for one (1) of four (4) incontinent care observations; Resident #15. Findings include: A review of the facility's policy entitled "Inservice Urinary Catheter Care", undated revealed, the catheter should be secured to the resident's leg with a catheter strap or type to prevent pressure on the catheter. If the resident is positioned on their side, the drainage bag should be on the side of the bed they are facing. This will ensure proper flow. The facility's policy entitled "Inservice Perineal/Incontinent Care", undated revealed: Wash from front to back using a clean cloth or clean area of the cloth for each stroke. Resident #15 On 6/11/18 at 11:05 AM, Resident #15 was	F 690	1. The catheter securing device for Resident #15 was replaced and Certified Nursing Assistant #1 and Certified Nursing Assistant #2 were immediately in-serviced on proper perineal/incontinence care and the proper positioning of the catheter bag during care by the Director of Nursing, a registered nurse on 6/11/18. The Director Of Nursing assessed Resident #15 for any trauma or negative effect from the missing catheter securing device on 6/11/18 and did not note and trauma or negative effect from the missing catheter securing device. 2. The center recognizes that all residents could have the potential to be affected by the same deficient practice. The Director of Nursing and Transitional Care Unit Manager, both Registered Nurses; the Minimum Data Set Licensed Practical Nurses #1 & #2, and the Medical Records Nurse, a Licensed Practical Nurse, have performed a	

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	255244	A. BUILDING _____ B. WING _____	06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

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F 690	Continued From page 11 observed in bed with an indwelling urinary catheter in place. This resident did not have the catheter tubing secured to her leg. Certified Nursing Assistants (CNAs) #1 and CNA #2, performed incontinent care and catheter care on Resident #15. During incontinent care, the CNAs positioned the resident onto her right side and left the catheter drainage bag hanging on the opposite side of the bed. While performing incontinent care, both CNA #1 and CNA #2 positioned the resident onto her right side, and CNA #1 wiped the resident from her back downward towards the front of her body. On 6/12/18 at 3:05 PM, interview with CNA #1 revealed she should have wiped the resident in an upward instead of downward motion from the front to the back of the resident's body. CNA #1 also stated that the resident need a "strap" so it (referring to the catheter tubing) would not "yank" out of her and could possibly harm the resident. On 6/12/18 at 3:15 PM, interview with CNA #2 revealed you should wipe from front to back. CNA #2 also stated the resident needed a "strap" to keep her catheter in place and the drainage bag should be placed on the side that the resident is turned, because the tubing could pull out of the Resident. On 6/12/18 at 3:20 PM, interview with the Director of Nursing (DON) revealed she noticed the CNAs had not been trained on incontinent care and catheter care upon her hire, so she and the staff trained the CNAs immediately. The DON also stated the CNAs have had ongoing training by Registered Nurse (RN) #1. The DON stated that the staff put the newly hired CNAs with a "seasoned" CNA and then will check them off.	F 690	perineal/incontinence care skills check off with all Nursing Personnel to ensure proper perineal care, incontinence care, and catheter care cabilities as of 7/6/18. 3. The Director of Nursing, a Registered Nurse, in-serviced on 6/29/18 all Nursing Staff on providing proper perineal/incontinence care, securing of catheter tubing, and proper placement of the catheter bag during care. The Director of Nursing and Transitional Care Unit Nurse, both Registered Nurses, will audit perineal care/catheter care as follows: 3 random observations daily for 1 week; 3 random observations 3 times a week for 1 week; 3 random observations twice a week for 2 weeks; and 3 random observations weekly for 4 weeks. 4. The results of the audits will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, for review and recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the Medical Director, Director of Nursing, Nursing Home Administrator and two additional member from the Social Services Director, Maintenance Director, Minimum Data Set Coordinator, Medical Records, Nurses, Certified Nursing Assistants, and Life Connections Coordinator.	

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	255244	A. BUILDING _____ B. WING _____	06/13/2018

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F 690	Continued From page 12 She stated a nurse observes the new CNA perform incontinent care and checks them off. The DON also stated females should be wiped from front to back, "internal to external" and a catheter "strap" should be in place, because the strap is to keep from causing trauma to the bladder. On 6/12/18 at 3:30 PM,interview with RN #1 revealed that she did some training's with the CNAs on incontinent care and catheter care, but it has been a while back. She sated the staff also watched a film on incontinent care. A review of the facility's Face Sheet reveals the resident was admitted on 8/18/17, with a diagnosis of Neurogenic Bladder.	F 690		

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	255244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/12/2018**

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SUNPLEX SUB-ACUTE CENTER	**6520 SUNSCOPE DRIVE** **OCEAN SPRINGS, MS 39564**

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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 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 code 1-5.4.6, and NFPA 101 section 9.6. The deficient practice affected all (3) smoke compartments and all (43) residents in facility on the day of survey. Findings Include:	K 341	This plan of correction serves as Sunplex Subacute Center's allegation of substantial compliance as of 7/6/18. This plan of correction does not constitute an admission or agreement by the provider, Sunplex Subacute Center, of the	7/6/18

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

Electronically Signed — 07/03/2018

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	255244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/12/2018**

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K 341	Continued From page 1 On 6/7/18 at 10:45 AM, observation revealed the fire alarm panel was showing "EARTH TROUBLE "signal during testing of the fire alarm system. The Maintenance Supervisor was unable to reset/cleared trouble signal during and on completion of the fire alarm test. The fire alarm system was able to function properly despite of the trouble signal on the panel. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 6/7/18.	K 341	truth of the facts alleged or conclusion set forth in this Statement of Deficiencies. This plan of correction has been respectfully developed solely because it is required by State and Federal Law. 1. The facility ensured the panel was functional and ensured that the new panel was on order as of 6/7/18. 2. The facility recognizes that all residents can be affected by the deficient practice. The facility has replaced the panel and has no fault indicators as of 6/15/18. 3. The nursing home administrator in-serviced the maintenance director on 6/7/18 on the requirement of maintaining an error/fault free fire system at all times. The maintenance director will monitor this panel once a week for 8 weeks to ensure no further issues exist with the panel. 4. The results of the audits will be reported to the quality assurance and performance improvement committee monthly by the maintenance director, for review and recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the medical director, director of nursing, nursing home administrator and two additional member from the social services director, maintenance director, minimum data set coordinator, medical records, nurses, certified nursing assistants, and life connections coordinator.	

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	255244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/12/2018**

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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 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	K 918	1. The facility had the generator repaired	7/6/18

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K 918	Continued From page 3 facility failed to properly inspect and do preventive maintenance of the generator as directed by NFPA 99 sections 6.4.4.1.1.3 and 6.4.4.2. Based on further observation while testing, the facility did not maintain the generator in accordance to NFPA 99 section 6.4.4 and NFPA 110 section 8.4.2. The deficient practice affected all (3) smoke compartments and all (43) residents in facility on the day of survey. Findings include: On 6/7/18 at 11:55 AM, observation revealed the generator was unable to transfer power to the facility within the required 10 seconds. The generator transferred power to the facility in 19 seconds. On 6/7/18 at 1:55 PM, the facility could not produce current documentation showing certified annual test of the generator over the last 12 months. The facility did produce an annual test of the generator dated 5/19/17 which was 1 month past due 12 month requirement. The findings were acknowledged by the Administrator and the Maintenance Director verified this observation during the exit interview on 6/7/18.	K 918	as of 6/7/18 to ensure that it transfers within 10 second. The facility also performed the annual generator test/maintenance on 7/2/18. 2. The facility recognizes that all residents can be affected by the deficient practice. The facility has repaired the generator as of on 6/7/18 and has performed the annual test as of 7/2/18. 3. The nursing home administrator in-serviced the maintenance director on ensuring the generator is annually certified on time and that the generator must be able to transfer power within 10 seconds, as of 6/7/18. The maintenance director will audit the generator and maintenance logs on a weekly basis for four weeks to ensure all generator maintenance is completed timely. The maintenance director will test the transfer time of the generator weekly to ensure it meets the 10 second transfer time for 8 weeks. 4. The results of the audits will be reported to the quality assurance and performance improvement committee monthly by the maintenance director, for review and recommendations by the committee for revisions, updates, or resolution. The committee consists of at least the medical director, director of nursing, nursing home administrator and two additional member from the social services director, maintenance director, minimum data set coordinator, medical records, nurses, certified nursing	

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K 918	Continued From page 4	K 918	assistants, and life connections coordinator.	

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E 000	Initial Comments Survey conducted on 6/12/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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