

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2019
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI			STREET ADDRESS, CITY, STATE, ZIP CODE 2279 ATKINSON ROAD BILOXI, MS 39531		
(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 A standard recertification survey was conducted by Healthcare Management Solutions (HMS) on behalf of the MS State Department of Health from 5/12/19 through 5/16/19. In addition, Complaint Intake Number MS15878 was investigated in conjunction with the standard survey. The complaint was not substantiated for Quality of Care and Treatment and resulted in no citations. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance related to the standard survey: F550, F623, F641, F644, F645, F 656, F657, F676, F684, F686, F698, F812, and F924. The facility's census on 5/12/19 was 121, and the facility held a license for 180 beds.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		7/2/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/21/2019

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and interviews, the facility failed to ensure the residents' dignity was not compromised for two (2) of 24 sampled residents, Residents #21 and #37. Specifically, staff posted signage visible to others regarding a resident's personal care (Resident #21), and the facility staff failed to provide privacy for one (1) resident (Resident #37), leaving the resident's skin and/or body exposed. Findings include:	F 550	The sign was removed from above Resident #21 s bed on 5/15/19 by the Regional Nurse Consultant. The Assistant Social Service Director (ASSD) visited Resident #21 and Resident # 37 on 6/18/19 to address any psychosocial concerns related to the failure to provide privacy during care, there were no negative outcomes identified. All resident's have the potential to be affected by the facility's failure to provide		

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F 550	Continued From page 2 Review of an undated facility policy titled, "Dignity and Respect," revealed, "It is the policy of this facility to treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life. 1. The staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings ...3. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtains shields the residents from passer-by. People not involved in the care of the resident shall not be present without the resident's consent while they are being examined or treated. Staff members shall knock before entering the resident's room. 4. Privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety ..." Resident #21 Review of Resident #21's Minimum Data Set (MDS), Significant Change Assessment, dated 03/05/19, revealed the facility admitted the resident on 04/19/17. Both of Resident #21's legs were amputated above the knee, with the most recent amputation (right leg) occurring on 02/25/19. The resident also had diagnoses which included Paraplegia, Quadriplegia, Type 2 Diabetes, Neurogenic Bladder, Pressure Ulcers-three (3), one (1) on his sacrum, one (1) on his left buttock and one (1) on his right buttock. According to the MDS assessment, the resident had impairment on both sides of his body; had an indwelling urinary catheter; was			F 550	privacy.The ASSD and Social Service Director (SSD) conducted audits of all resident rooms on 6/20/19 to ensure no other signs were posted related to specific resident care or information with no negative findings noted. In-service was initiated for all facility staff by the Director of Nursing (DON) on 6/18/19 and will be completed by 6/28/19 on resident rights regarding privacy and dignity to include providing privacy during care and posting of information related to a resident's care in areas where resident information can be viewed by others. The Social Service Director (SSD) and ASSD will make rounds beginning 6/20/19 on all units weekly x four, monthly x three then quarterly to observe for concerns related to privacy and dignity, take corrective action as needed and document findings. The SSD and ASSD will report findings from privacy and dignity rounds to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 550	Continued From page 3 always incontinent of bowel; and required extensive assistance with bed mobility, transferring, dressing, personal hygiene, and bathing. Observation, on 05/14/19 at 10:07 AM, of Resident #21's room, revealed the resident was in the bed nearest the entry door from the hallway. The resident's eyes were closed, and he was covered with a bedspread. There was a sign posted on the wall over the resident's bed which read, "Do not fasten brief. Keep brief loose under buttocks and peri area to prevent kinking of tubing." The sign was hand written on an 8 x 11 inch piece of paper. During an observation on 05/14/19 at 11:10 AM, of Resident #21's daily wound care, revealed the sign remained posted over the resident's bed. On 05/14/19 at 2:28 PM, observation of Resident #21's room, revealed the sign remained posted on the wall above his bed. Observation on 05/15/19 at 9:03 AM, of Resident #21's room, revealed the sign remained posted over the resident's bed. Interview on 05/15/19 at 09:10 AM, with Resident #21 revealed the sign had been on the wall over his bed for about two (2) months, since he returned from the hospital following the amputation of his right leg. Resident #21 stated he did not request placement of the sign, but staff let him know they were posting it on the wall. He could not remember which staff member talked to him about the sign. The resident said that due to the condition of his lower body, and the indwelling catheter tubing, he had discomfort at the genital	F 550			

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F 550	Continued From page 4 area if the brief was fastened. Review of Resident #21's physician's orders did not reveal placement of the sign was ordered. The care plan for Resident #21 included interventions for monitoring the resident's catheter tubing for kinks, and for observing the resident for any pain or discomfort related to the catheter. Interview, on 05/15/19 11:55 AM, with Certified Nursing Assistant (CNA) #1, revealed she thought the wound care nurse suggested the resident's brief should remain loose due to the resident's physical status, the recent amputation, the ongoing care of the resident's pressure ulcers, and the overall status of the resident's skin. CNA #1 stated she did not think the sign should be posted over the resident's bed. Instead, she said the information about the resident's brief could be communicated to nurses and CNAs at the change of each shift. CNA #1 said the information on the sign should remain confidential and should not become common knowledge for everyone who might enter the resident's room. Observation, on 05/15/19 at 12:30 PM, revealed the sign had been removed from the resident's wall. Interview on 05/15/19 at 12:40 PM, with Licensed Practical Nurse (LPN) #1, revealed the sign had just been taken down. The LPN stated she thought it was inappropriate for the sign to be posted over Resident #21's bed. She said it would alert staff to keep the resident's brief open, but visitors were also able to see the sign. She said staff should communicate resident care	F 550			

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F 550	Continued From page 5 needs at shift change. LPN #1 further stated the sign did not enhance the resident's dignity because while posted on the wall, it informed anyone who came into the room that the resident wore a "diaper." LPN #1 said the entire message on the sign was not appropriate, but she did not know when the sign was posted over the resident's bed, or who posted it. During an interview on 05/15/19 at 01:45 PM, with the Director of Nursing (DON), the DON revealed the sign should not have been posted over Resident #21's bed, and confirmed it was a dignity issue. She said the sign would inform anyone who came into the resident's room, such as visitors or non-clinical employees like maintenance staff, about the resident's personal care. The DON said she did not know who posted the sign. She said staff had other methods for communicating a resident's care needs which included; the Care Tracker system used by CNAs for updating and documenting care; another option was to communicate information about resident care during the verbal report between nursing staff that should occur at every shift change. Interview on 05/16/19 at 10:12 AM, with the facility's Administrator, revealed Departmental Staff were supposed to conduct daily rounds in assigned areas of the building, including the residents' rooms or living spaces. She said if staff persons identified concerns, they could report them at the morning meeting, so the issue(s) could be addressed as soon as possible. She said the staff who made the morning rounds had not reported any concerns with signage in residents' rooms.	F 550			

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F 550	Continued From page 6 Resident #37 Review of Resident #37's undated "Face Sheet" (a document that contains demographic and diagnoses information) located in the electronic medical record, revealed the resident was admitted to the facility on 2/27/19, and readmitted on 5/01/19. Resident #37's diagnoses list indicated the resident was admitted with pneumonia, acute and chronic respiratory failure and hypertension. Review of an admission MDS assessment, with the assessment reference date of 5/07/19, indicated Resident #37 scored a 15 (of 15) on the Brief Interview for Mental Status, indicating the resident was cognitively intact. Further review of the MDS assessment indicated the resident required two (2) staff assist for bed mobility, extensive two (2) staff assistance for transfers, dressing, toilet use and bathing and extensive one (1) staff assistance for personal hygiene. Review of Resident #37's current care plan for activities of daily living revealed the resident required staff assistance for eating, personal hygiene, toilet use, dressing and urinary incontinence. During an observation on 5/12/19 at 2:28 PM, Resident #37 was up in a wheelchair, sitting in the dining room. Her hospital gown was open in the back and pushed to the left side revealing the resident's back, left hip, thigh and part of her torso area. Interview with the RN/TCU (Transitional Care Unit) Unit Manager on 5/12/19 at 2:43 PM, following the observation of Resident #37 in the dining area, indicated she "thought she was the			F 550			

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F 550	Continued From page 7 resident was covered."	F 550			
F 623 SS=D	Observation on 5/13/19 at 12:06 PM, Resident #37 was up in a wheelchair and was being pushed down the hallway by the Respiratory Therapist. The resident's shirt was pulled up to her breast and was exposing her stomach area and her back. When asked, CNA #3 stated the resident's shirt should be pulled down. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		7/2/19	

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F 623	Continued From page 8 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623			

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F 623	Continued From page 9 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews, the facility failed to provide written notification to the Ombudsman regarding hospital transfers, for two (2) of six (6) residents who were reviewed for transfers, Resident #106 and Resident #46. Findings Include: Review of the facility's undated "Documentation	F 623	The Ombudsman was notified of the transfer for Resident #106 and Resident #46 on 5/15/19 by the Business Office Manager (BOM). The BOM reviewed all transfers for the past 60 days on 5/15/19 to ensure notification to the Ombudsman as required with no negative findings noted.		

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F 623	Continued From page 10 RE: Transfer/Discharge" revealed, "Policy Statement: It is the policy of this facility that when a resident is transferred or discharged his or her medical records be documented as to the reasons why such action was taken ...Procedure 5. Facility will notify the local ombudsman of the discharge and reason for the discharge. Review of an undated, written statement provided, and signed by the Administrator, confirmed there are no discharge/transfer logs for January and February 2019. Resident #106 Review of the electronic health record for Resident #106 revealed in January 2019, Resident #106 was discharged to the hospital for surgery. Further review of the record failed to produce any record of the Ombudsman being notified of the transfer of Resident #106 to the hospital. Resident #46 Review of the electronic health record for Resident #46 revealed in February 2019, Resident #46 was discharged to the hospital due to an Acute Ischemic Stroke. Further review of the record failed to produce any record of the Ombudsman being notified of the transfer of Resident #46 to the hospital. An attempt was made to review the Ombudsman notification records for January and February of 2019, and the facility failed to produce the requested records by the survey exit. On 5/15/19 at 10:15 AM, an interview with the Business Office Manager (BOM) was conducted. The BOM stated someone else was responsible	F 623	The BOM was in-serviced by the Administrator on 6/18/19 regarding notification of Ombudsman of all transfers per regulation. The BOM will maintain an ongoing log of transfers and notify the Ombudsman of all transfers monthly. The Admissions Nurse will audit all transfers from the facility beginning 7/1/19 monthly x three then quarterly to ensure all transfers have been communicated to the Ombudsman and document findings. The Admissions Nurse will report findings from transfer audits to the Quality Assurance and Performance Committee monthly and as needed for review, revision and/or resolution of the plan.		

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F 623	Continued From page 11 for notifying the Ombudsman in January and February 2019, and there were no records available for review to confirm the notifications were sent. On 5/15/19 at 10:20 AM, an interview with the RN Nurse Consultant (RNNC) was conducted. The RNNC confirmed there were no records available that documented the notification of the ombudsman of the two (2) hospital transfers/discharges.	F 623			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for two (2) Residents, Resident #112 and Resident #122, of 26 Residents reviewed for MDS accuracy. Specifically, the facility failed to accurately assess Resident #112's fall status and Resident #122's discharge status. Findings include: Review of an undated, written statement provided by the facility MDS Consultant documented, "The Pillars of Biloxi does not have a policy for MDS coding, but it is expected that the RAI (Resident Assessment Instrument) manual is followed when coding resident MDS assessments." Resident #112	F 641	The Minimum Data Set (MDS) for Resident # 112 dated 4/29/19 was modified by the MDS Nurse on 5/15/19 to reflect the fall prior to admission. The MDS for Resident # 122 was modified by the MDS Nurse on 5/15/19 to reflect discharge to the community. The MDS Nurse conducted an audit of MDS for all residents discharged in the past thirty (30) days with no negative findings noted on 6/19/19. The MDS Nurse conducted an audit of MDS for all residents admitted in the last thirty (30) days to ensure falls were coded correctly with no negative findings noted on 6/27/19. The MDS Nurse was in-serviced by the		7/2/19

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F 641	Continued From page 12 Review of Resident #112's admission MDS assessment, dated 4/26/19, revealed the resident had been admitted to the facility on 4/19/19, with diagnosis of a fractured right wrist from a fall at home. The MDS documented the resident had not had any falls in the last month prior to admission. Review of an "Admission History and Physical," dated 4/16/19, revealed " ...The patient fell and broke her right wrist on 4/2/19..." During an interview on 5/15/19 at 11:31 AM, the MDS consultant stated the MDS was not coded correctly for the fall prior to admission. She stated the resident had a fall with fracture on 4/02/19, before being admitted to the facility. Resident #122 A closed record review for Resident #122 revealed the information provided in the discharge MDS assessment documented the resident was discharged to an acute care hospital from the facility on 3/15/19. However, a review of the discharge note, dated 3/15/19, and found in the medical record, revealed the resident was discharged to his/her home. The noted stated, ""Resident left the facility at 1500 [3:00 PM] via private automobile with family members present." During an interview, conducted on 5/15/19 at 5:25 PM, with the MDS Care Plan Coordinator (CPC), the MDS CPC confirmed the MDS discharge information for Resident #122 was coded incorrectly. MDS CPC did not provide an explanation for incorrect information, in the resident's record, but confirmed Resident #122 was discharged from the facility to his/her home with family.	F 641	Administrator on 6/20/19 regarding proper coding of discharge status and falls on the MDS. The Assistant Director of Nursing (ADON) will audit five (5) MDS monthly x three (3) months then quarterly beginning 6/27/19 to ensure proper coding of falls/discharge status and document findings. The ADON will report findings from MDS audits to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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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 facility policy review, record review, and staff interview, the facility failed to provide a Level II Pre-Admission Screening and Resident Review (PASRR) for one (1) of three (3) sampled residents, Resident #21, reviewed for PASRR screenings. Specifically, Resident #21 was diagnosed with Schizophrenia after he was admitted to the facility, and no Level II PASRR was requested by the facility, as required, to ensure appropriate placement for a resident with a serious mental illness. Findings include: Review of the facility policy, titled "Physician Certification for Nursing Facility and MI/MR	F 644	A Pre-Admission Screening (PAS) was completed by the Business Office Manager (BOM) on 6/6/19 for Resident #21 to include the diagnosis of Paranoid Schizophrenia. The Admissions Nurse audited all resident records on 6/20/19 for the completion of PAS forms for new diagnoses of mental illness as required with no negative findings. The Administrator in-serviced the BOM on 6/18/19 regarding completing PAS forms for residents with new diagnoses of severe mental illness. All diagnosis		7/2/19

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F 644	Continued From page 14 Screening," revised 09/05/14, revealed the purpose of the screening was for the physician to certify that a resident was appropriate for admission to a long-term care Medicare/Medicaid facility. Additionally, the policy revealed Social Services (S.S.), the Admissions Coordinator, and Medical Records (MR) personnel (or MR designee) would be responsible for completing and submitting the PASRR screening documents to the State Agency. Review of the Admission Record in Resident #21's electronic clinical record, revealed an original admission date of 04/19/17, and a readmission date of 05/09/17. The Pre-Admission Screening (PAS) Level I Application for Long Term Care was completed on 05/16/17. According to the responses entered on the PAS application, Part B-Criteria for referral for Level II screening, the resident did not meet the criteria for a Level II screen. At that time there was no diagnosis of a major mental illness, no recent history of a major mental illness, and the resident was not taking psychotropic medications. Continued review Resident #21's Admission Record, revealed a diagnosis of Paranoid Schizophrenia was added on 05/16/17, after the resident had been admitted to the facility. Review of Resident #21's admission Minimum Data Set (MDS) Assessment, dated 04/21/17, revealed in "Section I: Active Diagnoses:" Paranoid Schizophrenia was not among the resident's diagnoses. Review of "Psychiatric Notes," dated 06/14/17, and 07/05/17, revealed the resident was assessed with disordered thought processes; with auditory hallucinations; as well as paranoia and	F 644	changes requiring a PAS update will be communicated to the BOM five days per week in the clinical start up meeting. The BOM will complete PAS Forms as indicated. The Admissions Nurse will audit eight resident records beginning 7/1/19 monthly x three then quarterly for diagnosis changes to ensure PAS updates are completed as required. The Admissions Nurse will report findings from record audits to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 644	Continued From page 15 persecution. The resident reported to the Psychotherapist that he believed staff were talking about killing him. Review of a MDS Significant Change Assessment, dated 03/05/19, revealed Paranoid Schizophrenia was listed among Resident #21's diagnoses. Review of Resident #21's current "Physician Orders," dated 05/15/19, revealed the resident had orders for Risperidone 1.5 milligram (mg) one (1) time per day, and for Risperidone 1.75 mg at bedtime. Risperidone is an antipsychotic medication used to treat Schizophrenia and Bipolar Disorder. Review of Resident #21's Comprehensive Care Plan (CP), revealed the CP included the resident's diagnosis of Paranoid Schizophrenia with interventions for management, and for the use of psychotropic medications. In an interview, on 05/15/19 at 4:21 PM, with the Business Office Manager (BOM), she stated that she was responsible for completing the PASRR Level I screening for newly admitted residents. She said the PAS date of 05/16/17, was the date the application was submitted to the State Agency. The BOM said she usually asked the Minimum Data Set (MDS) Nurse to review newly admitted resident's medications and to let her know if the resident was taking psychotropic medications. She said she was required to answer a question on the form about the resident's use of psychotropics. The BOM said she typically did not ask a nurse or physician to review the resident's diagnoses, because when she transmitted the completed Pre-Admission	F 644			

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F 644	Continued From page 16 Screening (PAS) Level I Application for Long Term Care, she also transmitted the resident's History and Physical, their Admission Face Sheet including diagnoses, and the physician's orders to the State Agency to review. She said the State Agency would review the information and would notify the facility if the resident needed a Level II screening. She said the State Agency would then send a representative to the facility to complete the Level II screening. The Business Office Manager stated in Resident #21's case, another PASRR application should have been submitted to the State Agency when the diagnosis of Paranoid Schizophrenia was added. She said, as far as she knew, there was no system in place that would alert her that a resident received a new diagnosis of a serious mental illness after their admission.	F 644			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		7/2/19	

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F 645	Continued From page 17 services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this	F 645			

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F 645	Continued From page 18 section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interview, the facility failed to complete a Pre-Admission Screening (PAS) prior to the resident's admission to a long-term care facility, as required. The facility's failure affected one (1) of five (5) residents reviewed for Pre-Admission Screening applications for long term care, Resident #37. Findings include: Review of a facility policy, titled "Physician Certification for Nursing Facility and MI/MR (Mental Illness/Mental Retardation) Screening," dated 9/15/14, revealed, "Policy: The Admission Coordinator or designee will obtain a current Medicare certification, Pre-Admission Evaluation PAE (TN) PAS (MS), and PASRR on all Medicare Part A admissions ...The Pre-Admissions Evaluation PAE (TN), PAS (MS) and PASRR are to be completed for Medicare A admissions including: a. New/Initial Medicare A admissions. B. Facility long-term care residents with qualifying hospitalization converting to Medicare A admission into facility." Review of Resident #37's undated "Face Sheet" (a document that contains demographic and	F 645	A Pre- Admission Screening (PAS) was completed by the Business Office Manager (BOM) on 5/13/19 for Resident # 37. The BOM audited all resident records on 6/20/19 to ensure all residents have a PAS form on file as required with no negative findings noted. The Administrator in-serviced the BOM on 6/18/19 regarding the completion of a PAS or PAS update as required for all new admissions and hospital returns. All new admissions and hospital returns will be reviewed five days per week during clinical start up meeting to ensure new admissions requiring a PAS are communicated to the BOM for completion. The Admission Nurse will audit eight new admission/ hospital return records beginning 6/25/19 monthly x three then quarterly for completion of PAS as required. The Admission Nurse will report findings from new admission/ hospital return audits to the Quality Assurance and		

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F 645	Continued From page 19 diagnoses information) found in the electronic medical record, revealed the resident was admitted to the facility on 2/27/19, and readmitted on 5/01/19. Resident #37's diagnoses included: Pneumonia, Acute and Chronic Respiratory Failure and Hypertension. Further review of Resident #37's electronic record lacked evidence of a PAS being completed for the resident, prior to admission in the long term care facility, as required. On 5/13/19 at 2:44 PM, a copy of the Pre-Admission Screening (PAS) was provided by Medical Records Director with the PAS date of 5/13/19. During an interview on 5/13/19 at 2:55 PM, with the Business Office Manager (BOM), she stated she was responsible for the PAS on the residents. She indicated she had just completed the PAS on 5/13/19. The BOM confirmed this was the first PAS that had been completed for Resident #37.	F 645	Performance Committee monthly for review, revision and/or resolution to the plan.		
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	F 656		7/2/19	

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F 656	Continued From page 20 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 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 facility policy review, record reviews, and interviews, the facility failed to ensure comprehensive, resident-centered care plans were developed and/or implemented for three (3) of 48 sampled residents, Residents #37, #89, and #112. Findings include:	F 656	The care plan for Resident # 37 was revised on 6/12/19 by the Minimum Data Set (MDS) Nurse on 6/12/19 . The comprehensive care plan for Resident # 89 was completed on 6/12/19 by the MDS Nurse to include history of falls and Urinary Tract Infection (UTI).The comprehensive care plan for Resident # 112 was completed by the MDS Nurse on		

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F 656	Continued From page 21 A review of an undated facility policy titled, "Care Plan - Comprehensive", revealed, "it is the policy of this facility to develop comprehensive care plans for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs." In addition, the policy stated, "The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's assessment or within twenty-one (21) days after the resident's admission, whichever occurs first." Resident #37 Record review of the undated care plans for Resident #37, revealed no care plan for the pressure ulcer to the right ischium. There were no interventions or goals related to the care of the pressure ulcer. Review of Resident #37's undated "Face Sheet" (a document that contains demographic and diagnoses information) in the electronic medical record, revealed the resident was admitted to the facility on 2/27/19, and readmitted on 5/01/19. Resident #37's diagnoses included: Pneumonia, Acute and Chronic Respiratory Failure and Hypertension. Review of an admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 5/07/19, revealed Resident #37 scored a 15 on the Brief Interview for Mental Status, indicating the resident was cognitively intact. Further review of the MDS, indicated Resident #37 required limited two (2) staff assist for bed mobility; extensive two (2) staff assistance for transfers, dressing, toilet use and bathing; and extensive one (1) staff assistance for personal hygiene. The MDS documented	F 656	5/15/19 to include a care plan for falls. All residents have the potential to be affected by this deficient practice. The MDS Nurse began audits of all residents comprehensive care plans on 6/12/19 and will complete by 7/1/19. The MDS Nurse will revise care plans as indicated. The Administrator in-serviced the Director of Nursing, Assistant Director of Nursing and MDS Nurse regarding the development and implementation of comprehensive care plans on 6/20/19. The MDS Nurse will audit five (5) resident records beginning 7/1/19 weekly x four (4), monthly x three (3) then quarterly for the development of comprehensive care plans and document findings. The MDS Nurse will report findings from record audits for the development of comprehensive care plans to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 656	Continued From page 22 Resident #37 had one (1) "unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar (dead tissue)." The MDS indicated the pressure ulcer was present upon admission. Review of the "Pressure Ulcer Report," dated 5/10/19, indicated the pressure ulcer to the right ischium measured 3.5 cm (centimeters) by 4.6 cm and was a Stage 3. Observation on 5/14/19 at 10:43 AM, with the RN Wound Nurse, revealed the pressure ulcer was clean and measured 2.8 cm by 4.1 cm and was a Stage 3. During an interview on 5/14/19 at 4:08 PM, the RN Wound Nurse confirmed there was not a care plan for the pressure ulcer to the right ischium for Resident #37. During an interview on 5/15/19 at 4:10 PM, the MDS Consultant confirmed Resident #37 did not have a care plan for the pressure ulcer to the right ischium. Resident #89 A review of Resident #89's, "Baseline Care Plan", dated 4/30/19, revealed the resident's care plan identified the following: A. Resident #89's Baseline Care Plan stated, "I am at risk for falls related to decreased mobility." The care plan gave instructions for facility staff to ensure the resident's call light was within reach and ensure the resident was wearing appropriate footwear. B. Resident #89's, "Baseline Care Plan" further indicated, "I have an infection." The care plan gave instructions to facility staff to ensure the resident's medication was administered as	F 656			

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F 656	Continued From page 23 ordered and observe the resident for worsening symptoms. Resident #89's clinical record did not contain a comprehensive care plan that addressed the residents history of falls or UTI, at the time of the review. The resident's record review was on 5/14/19, 26 days after Resident #89 was admitted to the facility. A review of Resident #89's admission assessment, dated 4/25/19, revealed the resident was admitted to the facility with diagnoses that included: Anemia, Cirrhosis, Urinary Tract infection (UTI), and Hip Fracture. The assessment indicated Resident #89 used a wheelchair for mobility and needed extensive assistance of two (2) persons and a Hoyer lift for transfers. The resident was also assessed to receive antibiotics for a UTI; as well as physical therapy, occupational therapy, and speech therapy services at the facility. During an interview with the Minimum Data Set (MDS) Care Plan Coordinator (CPC) on 5/14/19 at 5:47 PM, the MDS CPC confirmed Resident #89 only had a Baseline Care Plan at the time of the record review, and further confirmed he should have had a Comprehensive Care Plan completed and implemented. The MDS CPC did not provide an explanation for facility's failure to develop and implement a Comprehensive Care Plan for Resident #89. Resident #112 Review of Resident #112's medical records lacked documentation that a comprehensive care plan for falls had been developed and implemented.			F 656			

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F 656	Continued From page 24 Review of Resident #112's undated "Face Sheet" found in the electronic medical record, revealed the resident was admitted to the facility on 4/19/19. Review of Resident # 112 's list of "Medical Diagnosis" revealed the resident was admitted with a Fractured Right Radius (forearm) and a History of Falling. Review of Resident #112's admission MDS assessment, dated 4/26/19, and the resident's Care Area Assessment (CAA) for falls, dated 5/1/19, revealed the facility was to proceed in care planning Resident #112 for falls. Care Areas are triggered by MDS responses and indicate a need for additional assessment or action for the identified care concerns. During an interview on 5/14/19 at 5:40 PM, the MDS CPC stated the resident only had baseline admission care plan. She confirmed the comprehensive care plan should have been completed and should include falls. The resident had been in the facility for 25 days and had no comprehensive, resident-centered care plan with measurable goals to achieve and/or maintain the resident's highest level of well-being. During an interview on 5/16/19 at 11:00 AM, the MDS Consultant confirmed the comprehensive care plan should be completed and implemented no later than 21 days after a resident's admission.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		7/2/19	

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F 657	Continued From page 25 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy reviews, record reviews, observations, and interviews the facility failed to ensure the care plan was updated to include all interventions to prevent falls and/or minimize injuries from falls for one (1) of 24 Residents, Resident #51, reviewed for safety, supervision and/or falls. Findings include: Review of an undated facility policy, titled "Care Plans - Comprehensive," revealed, "It is the policy of this facility to develop comprehensive care	F 657	The Care plan for Resident # 51 was revised by the Minimum Data Set (MDS) Nurse on 6/12/19 to include low bed and fall mat implemented for falls. The Assistant Director of Nursing (ADON) audited the care plans of all residents identified at risk for falls on 6/20/19 to ensure interventions for falls were included. One hundred nine (109) residents were identified at risk for falls. The Director of Nursing (DON)		

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F 657	Continued From page 26 plans for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs ...4. Care plans are revised as changes in the resident's condition dictates. Reviews are made at least quarterly ..." Review of an undated "At risk for falls" care plan, revealed interventions of: "Bolsters on bed; Encourage resident to wear appropriate footwear when ambulating or mobilizing in wheelchair; Fall risk eval on admit, quarterly and prn (as necessary); PT (Physical Therapy) evaluate and treat as ordered and prn; Review information on past fall to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes, tilt wheelchair to prevent forward leaning." The care plan lacked the interventions for a low bed and mats on the floor at her bedside, that were currently being implemented by facility staff. An observation of Resident #51 on 05/12/19 at 8:42 AM, revealed the resident laying in a low bed, with a mat on the floor, visiting with a family member. The family member stated she had asked the staff to place a mat on the floor because she did not want Resident #51 to be hurt from falling out of bed. Review of Resident #51's undated "Face Sheet" found in the electronic medical record, revealed the resident was admitted to the facility on 03/21/19, with diagnoses that included: Cerebral Infarction, Non-traumatic Subarachnoid Hemorrhage, Muscle Weakness and Hypertension.	F 657	in-serviced all Licensed Nurses regarding interventions for fall prevention, care plan revision and timing beginning 6/19/19 and ending 6/28/19. All residents with falls will be reviewed by the clinical team including the DON, ADON and MDS Nurse five (5) days per week during the clinical start up meeting to ensure interventions are initiated beginning 6/21/19. The ADON will audit care plans of residents with falls beginning 6/27/19 weekly x four (4), monthly x three (3) then quarterly to ensure all interventions are included in the comprehensive careplan. The ADON will report findings from care plan audits of residents with falls to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 657	Continued From page 27 Review of the Admission Minimum Data Assessment (MDS) with an assessment reference date of 03/28/19, revealed Resident #51 had long and short-term memory problems, and was moderately impaired with decision making. The resident required extensive assist of two (2) staff for bed mobility, transfer, toilet use, and required extensive one (1) staff assist for dressing, eating, and personal hygiene. The MDS also documented Resident #51 had a history of falls prior to entering the facility. Review of the CAA (Care Area Assessment) dated 03/28/19, revealed Resident #51 had difficulty maintaining sitting balance and impaired balance during transitions. The CAA indicated the resident had a potential for falls. During an interview on 5/14/19 at 3:00 PM, the MDS Coordinator confirmed the interventions of the low bed and mat to floor should have been added to the fall care plan for Resident #51. During an interview on 05/15/19 at 1:45 PM, the DON confirmed the care pan had not been updated to include the interventions for a fall mat and the low bed. She confirmed the care plan was not accurate, and it should include all interventions to prevent falls or reduce injuries from falls.	F 657			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to	F 676			7/2/19

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F 676	Continued From page 28 ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and record review the facility failed to provide a means to communicate for one (1) of two (2) sampled residents reviewed for communication deficits. Specifically, Resident #41's primary language	F 676	The translation phone number was posted at each nurses station by the Regional Nurse Consultant (RNC) on 5/15/19. The Life Connection Coordinator (LCC) will provide visual aids for Resident		

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F 676	Continued From page 29 was not English. There was no interpreter in the facility who could translate, and the facility had not arranged for devices and/or services to communicate with the resident in a manner that the resident could understand. Findings Include: A communication policy was requested from the facility during the survey. The Registered Nurse Consultant (RNC) provided a written, signed statement, dated 5/15/19, that confirmed the facility does not have a policy related to interpreter phone usage. Review of Resident #41's quarterly Minimum Data Set (MDS), dated 3/20/19, revealed: "Does the resident need or want an interpreter to communicate with a doctor or health care staff? Answer-No. There is no preferred language listed for Resident #41, but the resident speaks Vietnamese only. Review of the care plan with a revision date of 5/26/2017, read: "Focus: I have a communication problem r/t [related to] speaks limited English/primary language Vietnamese. Goal: I will be able to make basic needs known through the review date revised on 03/27/2019. Intervention: COMMUNICATION: Resident prefers to communicate in Vietnamese." On 5/12/19 at 11:48 AM, an interview with Registered Nurse (RN) #4 was conducted. RN #4 stated Resident #41 speaks Vietnamese and does not speak English. RN #4 stated staff communicate with Resident #41 speaking in English and using hand gestures, and Resident	F 676	# 41 to assist with communication on 6/21/19. Three other residents were identified as having a primary language other than English. The three residents identified will be provided with visual aides to assist with communication by the LCC on 6/21/19. An information sheet including the translator hotline phone number was added to the admission packet for all new admissions on 6/21/19. The Director of Nursing in serviced all staff beginning on 6/19/19 and ending on 6/28/19 regarding utilizing the translator hotline when needed for residents that do not speak English including the location of the hotline number at the nurses 'stations and how to communicate with residents using visual aids. The Admission Nurse will observe all newly admitted residents to the facility upon admission to ensure that all residents admitted to the facility can communicate needs and to determine if the resident requires visual aids to assist with communication. If a resident requires visual aids to assist with communication, they will be provided upon admission. The LCC will audit new admissions beginning 6/28/19 weekly x four, monthly x three then quarterly to ensure visual aids and the translator hotline is utilized for residents that require assistance with communicating related to language barrier. The LCC will report findings from audits of residents with language barriers to the		

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F 676	Continued From page 30 #41 appeared to understand some English, but responds only in Vietnamese. RN #4 also stated no other type of communication (communication board, interrupter, language phone line) is used to communicate with Resident #41. RN #4 said there were no communication boards available in the facility for residents with communication concerns to use. On 5/12/19 at 2:45 PM, an interview with Life Connection Assistant (LCA) #2 was conducted. LCA #2 stated Resident #41 does participate in some activities such as ball toss, connect 4, and movies, but the visits are limited due to the language barrier. On 5/12/19 at 4:02 PM an interview with Licensed Practical Nurse (LPN) #2 was conducted. LPN #2 stated there is a communication barrier with Resident #41. The LPN states they use simple questions and the resident responses appear reliable and relevant to questioning. LPN #2 stated there is no communication board, language phone line, or interpreter available to communicate with Resident #41. On 5/14/19 at 3:06 PM, an interview with LCA #1 was conducted. LCA #1 stated he uses hand gestures to communicate with Resident #41. Resident #41 appears to understand some English but does not speak English. Resident #41's responses appear appropriate to questioning. LCA #1 stated he attempted to use his phone to translate at times. LCA #1 stated no staff speak Vietnamese and no language line is available for use. On 5/14/19 at 3:45 PM, an interview with the Social Service Director (SSD) was conducted.	F 676	Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 676	Continued From page 31 The SSD stated there are no staff who speak Vietnamese and Resident #41 has no family or friends involved in his care. The SSD stated Resident #41 can read written questions and respond appropriately. The SSD also stated there in no language phone line available for use. On 5/14/19 at 4:07 PM, an interview with the Minimum Data Set (MDS) Care Plan Coordinator (CPC) was conducted. The MDS CPC stated Resident #41 speaks very little English and there are no staff who speak Vietnamese. The MDS CPC stated there is a language phone line available for use in the facility. On 5/14/19 at 4:07 PM, an interview with the MDS Consultant (MDSC) was conducted. The MDSC stated there is a language phone line available for use in the facility. On 5/15/19 at 4:10 PM, an interview with the RNC was conducted. The RNC stated there is a language phone line available for use in the facility, but there is no formal training provided to staff for the use of the language/interpretive phone line. Observation on 5/12/19 at 12:15 PM, of Resident #41 in is room, revealed he was seated on the bed responding to RN #4's questioning. Resident #41 responded to questions by shaking his head.	F 676			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684			7/2/19

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F 684	Continued From page 32 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies, and interview, the facility failed to ensure a resident with a diagnosis of Congestive Heart Failure (CHF) was weighed daily as ordered by the physician, for one (1) of one (1) resident's reviewed for daily weights, Resident #102, in a sample of 24 residents. This had the potential to cause a delay and/or alteration in treatment for Resident #102, according to weight loss or gain. Findings include: Review of a facility policy, titled "Weights; Obtaining and Documenting," dated 12/27/17, revealed " ...Timing of Weights: 1. Daily; Daily weights should be done if ordered by the physician ..." Record review of Resident #102's admission Minimum Data Set (MDS) assessment, dated 4/25/19, revealed the resident was re-admitted to the facility on that date after an acute hospitalization. The MDS revealed in "Section I" the resident had diagnoses of Hypertension, Heart Disease, and Dementia. An observation of Resident #102 on 5/13/19 at 9:38 AM, revealed the resident was lying in bed, in her room. Her hands and arms were observed to be edematous (swollen).	F 684	Resident # 102 was assessed by the Nurse Practitioner on 5/17/19 and transferred to the hospital for evaluation. All resident records were audited on 6/20/19 by the Assistant Director of Nursing (ADON) for daily weight orders two (2) other residents were noted to have orders for daily weights with no negative outcomes identified. The ADON in-serviced all Licensed Nurses regarding obtaining and documenting daily weights as ordered by the physician beginning on 6/19/19 and ending on 6/28/19. The ADON will audit all resident records with orders for daily weights to ensure weights are recorded beginning 6/27/19 weekly x four (4), then monthly x three(3)and document findings. The ADON will report findings from weekly weight audits to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 684	Continued From page 33 During an interview on 5/13/19 at 9:41 AM, Registered Nurse (RN) #2 stated the resident had gone to the hospital recently, and had been edematous since she came back. Review of the "Progress Notes," dated 5/02/19, revealed the Nurse Practitioner assessment, " ... Chief complaint CHF, inadequate diuresis ...resident with recent hospitalization ...while admitted had CHF and put on #30 fluid at the time of discharge. I started her on Lasix (a diuretic) 40 daily, increasing it to bid (twice a day), she has only lost #3 (pounds) ... Plan: D/c (discontinue) Lasix 40 bid, Bumex (a diuretic) 1 mg(milligram) one po bid, daily weights ..." Review of the resident's Physician's "Order Summary Report" revealed "5/02/19 ...Daily weight one time a day for fluid retention ..." Review of the resident's "Daily Weight" record revealed the resident's weight on 5/03/19 was 197 pounds. There was a lack of documentation of the resident's daily weights for 5/04/19, 5/05/19, and 5/06/19. Review of Resident #102's care plans, dated 8/17/18, revealed "I am on diuretic therapy r/t (related to) edema ...Obtain weight as ordered ...I have altered cardiovascular status r/t ...HF (Heart Failure) ...observe/document/report PRN (as needed) any s/sx (signs and symptoms) of Congestive Heart Failure: edema ...weight gain ..." During an interview on 5/14/19 at 1:50 PM, Certified Nursing Assistant (CNA) #5 stated she was a restorative CNA and they were responsible for the daily weights. She stated she weighed the	F 684			

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F 684	Continued From page 34 resident on 5/03/19, and at that time the resident was on weekly weights, she was not aware the resident had been put on daily weights until 5/07/19. During an interview on 5/14/19 at 4:00 PM, RN #1, stated she had worked on 5/04/19, 5/05/19 and 5/06/19. She stated she had notified the Director of Nursing (DON) on 5/06/19, that the weights had not been done. The DON had told her to notify the restorative CNA to do the daily weights.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review, record reviews, and interviews the facility failed to provide the treatments as ordered for a pressure ulcer for one (1) of five (5) residents, Resident #104, reviewed for pressure ulcers, in a sample of 24 residents. Not providing treatment as ordered, had the potential for the pressure ulcer	F 686			7/2/19
			The wound dressing was removed from Resident # 104 on 5/16/19 by the Wound Nurse (WN). The WN assessed Resident # 104 s wound on 5/17/19 with improvement noted. The wound was resolved on 5/31/19.		

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F 686	Continued From page 35 to deteriorate. Findings include: Review of a facility's policy titled "Skin Care Process", dated 1/17/18, revealed, "It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur ...1. Provides treatment according to physician's orders ..." Review of Resident #104's undated "Face Sheet" found in the electronic record, revealed the resident was admitted to the facility on 6/19/18, with the diagnoses of Type II diabetes Mellitus, Cerebral Infarction, and Anxiety Disorder. Review of a quarterly Minimum Data Set (MDS) with the assessment reference date of 4/30/19, revealed Resident #104 had a BIMS (Brief Interview for Mental Status) of 15, which indicated the resident was alert and oriented. The MDS indicated Resident #104 required extensive assist of two (2) staff for bed mobility, transfer, dressing toilet use and personal hygiene. The MDS documented Resident #104 did not have any pressure ulcers at the time of the assessment. Review of an undated care plan for pressure ulcers, revealed Resident #104 had a Stage 2 pressure ulcer to the left medial thigh. The interventions for the Stage 2 pressure ulcer were: "Administer medications as ordered; Monitor/document for side effects and effectiveness; Administer treatments as ordered and monitor for effectiveness; Assess/record/observe wound healing; Measure	F 686	Fifteen(15) residents were identified with pressure ulcers. The Director of Nursing (DON) observed all residents with pressure sores and current treatment orders on 6/20/19 to ensure treatments were completed as ordered with no negative findings noted. The DON in-serviced all Licensed Nurses regarding performing wound treatments as ordered and dating of treatments beginning on 6/20/19 and ending on 6/28/19. The DON will observe two(2) residents beginning 6/28/19 three(3)x per week x four(4), monthly x three(3) then quarterly to ensure that treatments or completed as ordered, take corrective action as necessary and document findings. The DON will report findings from treatment audits to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 686	Continued From page 36 length, width, and depth where possible; Assess and document status perimeter, wound bed and healing progress; Report improvements and declines to the MD (Medical Doctor). Observe nutritional status; Serve diet as ordered, monitor intake and record; Observe/document/report PRN (as necessary) any changes in skin status: appearance, color, wound healing, s/s (signs and symptoms) of infection, wound size (length x(times) width x depth), stage comfort; Treat pain as per orders prior to treatment/turning to ensure the resident's comfort; Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate." Review of the facility's "Pressure Injury Log," dated 5/10/19, revealed Resident #104 had a facility acquired pressure ulcer measuring 1.7 by .06 centimeters (cm) which was fluid filled. The treatment order was betadine twice a day. Review of the 05/2019 "Treatment Administration Record," specified "wound care apply betadine and tented border gauze to Stage 2 pressure ulcer of L (left) medial thigh, 7-10 AM and 7-10 PM. Start date 5/03/19." Further review of the treatment record indicated the dressing was not completed at all on 5/04/19, the morning of 5/06/19, the afternoon of 5/08/19, and the morning 5/12/19. On 5/12/19 at 1:04 PM, the dressing to Resident #104's left thigh was observed with a date of 5/10/19, the initials on the dressing were smeared and unreadable. The resident stated she had gotten a blister from her compression stocking. Resident #104 stated the dressing had not been changed twice a day as ordered on 5/11/19 and	F 686			

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F 686	Continued From page 37 5/12/19. During an interview on 5/14/19 at 8:50 AM, Resident #104 stated the midnight nurse had changed the dressing. The resident said the dressing to her left thigh was to be changed twice a day, and that was not done on 5/13/19 as ordered. The date on the dressing was observed as 5/14/19. During a telephone interview on 5/15/19 at 11:AM, the RN Wound Nurse indicated she had changed the dressing on 5/14/19, and the daily dressing changes had not been getting done. The Wound Nurse said she changed the dressings weekly when she did wound measurements, and the floor nurses did the daily treatments. During an interview on 5/15/19 at 1:00 PM, the RN TCU (Transitional Care Unit) Unit Manager (UM) confirmed the dressings should have been done, and she would look into the matter. The TCU UM did not provide any additional information regarding why the dressing changes had not been done. At 1:22 PM, the TCU UM stated she had not been aware the dressings had not been done as ordered for Resident #104. The RN Wound Nurse completed a dressing change on 5/16/19 at 8:10 AM. The Resident #104 agreed to an observation of the dressing change. Appearance of the pressure ulcer revealed the fluid in the blister had been absorbed and the wound bed was dry. The RN Wound Nurse stated she was going to call the Nurse Practitioner because the wound had improved, and she now needed the dressing order discontinued to leave the wound open to air to heal.			F 686			

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and staff interviews, the facility failed to maintain ongoing communication and collaboration with the dialysis facility for one (1) of one (1) residents reviewed for dialysis services (Resident #106) in a sample of 24 residents. Findings Include: Review of the "Dialysis-Hemodialysis" policy, Nursing Services-21, dated March 23, 2010 read: "Policy Statement: Residents with end stage renal disease undergoing dialysis will receive care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The care and services will meet current standards of care ...This facility will co-ordinate care with the dialysis provider ...Medical and administrative information necessary for dialysis related care of the resident will be shared and communicated between the facility and the dialysis provider." The "Clinical Practice Guideline Dialysis-Hemodialysis", dated March 24, 2010 read: "Nutrition/Hydration, 5. Weight should be obtained weekly or as ordered by the physician. Pre and post dialysis weights will be obtained from the dialysis provider and sent to the facility	F 698	The Director of Nursing (DON) contacted the dialysis unit and spoke with the Dialysis Nurse regarding communication forms for Resident #106 on 6/21/19. The Dialysis Nurse reported that Resident #106 was often noncompliant with returning the communication form to the facility. Resident #106 is cognitively intact. The DON educated Resident #106 on 6/21/19 regarding returning communication forms to the nurse. Resident #106 voiced understanding of the importance of returning communication forms. Three other residents were noted to attend dialysis by the Assistant Director of Nursing (ADON) on 6/20/19. There were no problems noted with receiving communication forms back from the dialysis unit for these residents. The ADON in-serviced all licensed nurses beginning on 6/19/19 and ending on 6/25/19 regarding ensuring that all residents receiving dialysis have a communication form completed and sent to dialysis and that communication forms are returned to the facility and filed in the		7/2/19

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F 698	Continued From page 39 for inclusion in the medical record. Review of Resident #106's "Admission Record", dated 1/22/19, revealed the resident was initially admitted on 12/17/17, with diagnoses including End Stage Renal Disease, and dependence on Renal Dialysis. Review of the "Physician Orders" dated 8/16/18, for Resident #106 revealed, "Dialysis M-W-F [named clinic] Biloxi, chair time 12 PM." Review of the electronic medical record for Resident #106, dated 3/18/19 through 5/20/19, revealed four (4) completed "Dialysis Transfer Forms" dated 3/18/19, 5/06/19, 5/08/19, 5/13/19. Based on the physician order for three (3) visits each week, there were 25 visit opportunities during this date range. On 5/14/19 at 3:30 PM, an interview with Licensed Practical Nurse (LPN) #1 was conducted. LPN #1 stated the dialysis sheets are collected by "Medical Records" for placement into the resident's record. On 5/15/19 at 11:20 AM, an interview with Medical Records (MR) was conducted. The MR staff confirmed the only completed communication forms for Resident #106 are dated 3/18/19, 5/06/19, 5/08/19, and 5/13/19. The MR staff also stated the facility does not always get the communication sheets back from the resident. On 5/15/19 at 12:30 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated she had no knowledge of why the documents for the dialysis visits were not in the	F 698	resident record. The accepting nurse will contact the dialysis unit if the communication form is not returned to request the form. The ADON will audit the records of all residents receiving dialysis to ensure dialysis communication forms are included in the medical record beginning 6/27/19 weekly x four(4), then monthly x three(3), take correction action as necessary and document findings. The ADON will report findings from record audit for dialysis communication to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 698	Continued From page 40	F 698			
F 812 SS=F	medical record for Resident #106. The DON stated the dialysis center orders labs and reviews the results and then communicates the results to the facility. The DON also stated she was not aware of the missing communication sheets between the facility and the dialysis center for Resident #106 until she was asked about it. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy reviews, observations, and staff interviews the facility failed to store, prepare, and serve food under sanitary conditions for 117 of 121 residents who receive food from dietary services in the facility. Specifically, food was improperly stored in the walk-in freezer, and prepared without staff wearing appropriate hair	F 812			7/2/19
			The Lead Supervisor (LS) in the kitchen removed the food from the freezer and discarded on 5/12/19. Beard guards were put in use on 5/12/19 by all staff with facial hair. All residents who receive food from		

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F 812	Continued From page 41 covers in the facility's kitchen. The facility reported a census of 121 at the time of the survey, with four (4) residents received tube feedings. Findings Include: The "Staff Attire" policy, Dining Services Policy and Procedure Manual, HCSG Policy 024, dated 9/17, read "Policy Statement: All employees wear approved attire for the performance of their duties...Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained." The "Food Storage: Cold Foods" policy, Dining Services Policy and Procedure Manual, HCSG Policy 019, dated 9/17, read "Policy Statement: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated will be appropriately stored in accordance with guidelines of the FDA Food Code...Procedures...5. All foods will be stored wrapped or in covered containers, labeled dated, and arranged in a manner to prevent cross contamination." Observation on 5/12/19 at 9:01 AM, in the kitchen, revealed Dietary Aide (DA) #1 with facial hair on his chin approximately 0.25-0.50 inch in length. The DA was working in the food preparation area of the kitchen and plating fruit for lunch without wearing a facial hair cover. Observation on 5/12/19 at 9:20 AM, in the kitchen, revealed the Lead Supervisor (LS) who had a beard approximately 0.25-0.50 inch in length. The LS was working in the food	F 812	dietary had the potential to be affected. All food in the freezer was observed for any indication of freezer burn with no other concerns noted on 5/12/19 by the Dietary Manager (DM). The DM educated all dietary staff regarding the proper use of beard guards on 5/12/19. The gasket was replaced on the freezer to prevent ice buildup on 6/17/19 by the Maintenance Director. The DM in-serviced all dietary staff regarding beard guards and reporting any equipment not functioning and/or closing properly to the DM and recording in the maintenance log beginning 6/19/19 and ending on 6/28/19. The DM will observe the freezer for ice buildup, food in freezer for signs of freezer burn, take corrective action as necessary and document findings weekly beginning 6/20/19. The DM will observe staff for appropriate use of beard guards beginning 6/20/19 five (5)x per week x four (4) weeks and document findings. The DM will report findings from audits of freezer and beard guards to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		

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F 812	Continued From page 42 preparation area of the kitchen not wearing a facial hair cover. Observation on 5/12/19 at 9:30 AM, in the kitchen, revealed the Dietary Manager (DM) who had a beard approximately 0.25-0.50 inch in length. The DM was also working in the food preparation area of the kitchen not wearing a facial hair cover. Observation on 5/12/19 at 9:20 AM, at the walk-in freezer, revealed an ice build-up that prevented the door from closing properly. The ice was approximately one (1) inch wide and three (3) inches in length. There was also ice and frost build-up on the left side of the door entering the freezer. The build-up was approximately two (2) inches thick and ran approximately 18-20 inches in length from the inside corner of the unit to approximately two-three inches into the doorway. The ice build-up was preventing the freezer door from completely closing. The freezer temperature was not affected. Additional observations in the freezer on 5/12/19 at 9:23 AM, revealed a 10 pound (lb.) box of sandwich steaks contaminated by the ice build-up located on the left side of the cooling unit that had dripped down onto the open box of meat. There was also an open box containing six 5.33-ounce frozen beef patty fritters which had freezer burn. The LS disposed of the boxes and contents at the time of the observation. On 5/12/19 at 1:40 PM, an interview with the DM was conducted. The DM confirmed he was not wearing a facial hair cover while in the food preparation area of the kitchen. The DM also confirmed LS and DA #1 were not wearing facial	F 812			

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F 812	Continued From page 43 hair covers in the food preparation areas and should have been. The DM stated both staff members were educated on the wearing of facial hair restraints.	F 812			
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility policy the facility failed to ensure all corridors had handrails firmly secured and affixed to the corridor walls. Observations conducted on 5/12/19, and 5/15/19, revealed 15 loose handrails in four (4) of four (4) corridors of the facility. Findings include: Review of the undated facility policy titled "Monthly Handrail Inspection" indicated the facility was responsible for ensuring handrails were inspected monthly. The policy stated, "Check all hand rails in hallways. Make sure that hand rails are secure, painted, and in proper repair." Review of the facility's checklist titled, "Monthly Hand Rail Inspection Checklist", dated 8/16/18 through 4/16/19, revealed inspections documented for the past nine (9) months identified no loose handrails in the facility. Random observations conducted during an initial tour of the facility on 5/12/19 at 8:45 AM, revealed loose handrails located in all four (4) corridors of the facility.	F 924	All loose handrails were tightened in all four (4) corridors by the Maintenance Director (MD) on 5/16/19. All handrails in the facility were observed by the MD on 5/16/19 and no other handrails were noted to be loose. No residents were affected by the deficient practice. The Administrator in-serviced all staff regarding reporting loose handrails by documenting in the maintenance log located at each nursing station beginning 6/21/19 and ending 6/28/19. The MD will check all handrails in the facility beginning 6/17/19 two(2)x per week x eight(8) weeks then monthly, tighten as needed, and document findings. The Administrator will report findings from audits of handrails to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.	7/2/19	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2019
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI			STREET ADDRESS, CITY, STATE, ZIP CODE 2279 ATKINSON ROAD BILOXI, MS 39531		
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F 924	Continued From page 44 During environmental observations, conducted with the Maintenance Director present, on 5/15/19 at 11:29 AM, 15 handrails were identified as loose or broken, or not securely affixed to the wall. The following handrails were identified and confirmed to be in disrepair by the Maintenance Director: 1. Loose handrail located in front foyer entrance on the left side. 2. Loose handrail located between Room 109/110. 3. Loose handrail located between Room 110/111. 4. Loose handrail located between Room 103/104. 5. Loose handrail located between Room 111/112. 6. Loose handrail located between Room 105/106. 7. Loose handrail located between Room 106 and corridor doorway. 8. Loose handrail located next to Room 113. 9. Loose handrail located outside the main dining unit. 10. Loose handrail located outside Room 226. 11. Loose handrail located outside Room 401. 12. Loose handrail located outside Room 403. 13. Loose handrail located outside shower room on the 400 unit. 14. Loose handrail located outside Room 418. 15. Loose handrail located outside Room 422. An interview conducted with the Maintenance Director on 5/15/19 at 12:02 PM, revealed the Maintenance Director had not identified the loose handrails prior to the environmental tour and confirmed there were 15 handrails identified as loose or broken. The Maintenance Director had	F 924			

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F 924	Continued From page 45 no explanation for why the handrails were not identified during the monthly handrail inspections during the last eight (8) months.			F 924			

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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 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide clear and unobstructed corridors as directed by NFPA 101 section 19.2.3.4. This deficiency affected one (1) of five (5) smoke compartments and 11 of 121 residents in the facility on the day of survey. Findings include: On May 13, 2019 at 1:15 PM, observation revealed empty barrels obstructing the main corridor leading to the Laundry Room of the facility. The empty barrels were not in use by staff during the time of survey.	K 232	1.Barrels were removed from the main corridor on 5/13/19 by the Laundry Supervisor. 2.All residents have the potential to be affected 3.The Administrator in-serviced all staff regarding keeping corridors clear of items that may obstruct exit beginning on 6/21/19 and ending on 6/25/19. The Administrator will make rounds through entire facility weekly to ensure corridors serving as an exit access remain clear. 4. The Administrator will report findings		7/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/21/2019

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

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K 232	Continued From page 1	K 232	from weekly rounds to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect corridors as per NFPA section 19.3.6.1. This deficiency affected two (2) of five (5) smoke compartments and 41 of 121 residents in the facility on the day of survey. Findings include: On May 13, 2019 at 1:45 PM, observation revealed the Sitting Room and Activity Room were not hard-wired smoke detector. Sitting Room and Activity Room were open to the main corridor of the facility.	K 347	1.Hard wired smoke detectors were installed in the Sitting and Activity rooms. 2. All residents have the potential to be affected. 3. The Administrator in-serviced all maintenance personell on 6/20/19 regarding requirement for smoke detection systems.The Maitenance Director will make rounds of the entire facility monthly to ensure smoke detectors are in place as required and report any negative findings to the Administrator. 4.The Administrator will report any negative findings from monthly rounds regarding smoke detection to the Quality Assurance and Performance Committee monthly for review, revision and/or resolution of the plan.	7/2/19	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/13/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000			

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