MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	69SC	A. BUILDING: _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETE DATE
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;	M 500		4/28/19

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M 500	Continued From page 1 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have	M 500		

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M 500	Continued From page 2 policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and	M 500		

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M 500	Continued From page 3 possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interview, and review of facility's resident admission information, the facility failed to ensure eight (8) of eight (8)supplemental residents, Residents #5, #10, #14, #22, #33, #48, #72, and #76, were informed of location of the facility's most recent survey results and plan of correction, and of their right to review those results without the assistance of staff; and, failed to ensure eight (8) of eight (8) supplemental residents who attended the Resident Council Group meeting, Residents #5, #10, #14, #22, #33, #48, #72, and #76, were informed of their right to file a complaint to the State Survey Agency about the care and services they receive, and to be informed of additional advocacy groups available to them.	M 500	1. On April 1, 2019, the facility Administration updated the Residents Rights information to include location of survey results and contact information for the Mississippi Department of Health. On April 3, 2019, Social Services initiated distribution of the Residents Rights Information and location of survey results to all residents and/or family members. On April 25, 2019, the Administrator will attend resident council and update council on the following: survey results from March 2019, location of survey results, updated Resident Rights information that were distributed. On April 4, 2019, Resident #5 received Residents Rights Information and location of survey results.	

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M 500	Continued From page 4 Findings include: A. Review of the facility's undated brochure titled, "A Matter of Rights-A Guide to your Rights and Responsibilities as a Resident," indicated: "Ready Access to information. Your right to have prompt and convenient access to information includes . . . We will post the results of the most recent inspection of our facility, together with any plan of correction currently in effect. We encourage residents and family members to review these . . . You have the right to be kept informed about the things that affect you. You also have the right: to read the facility's latest survey inspection results and any plan of correction in effect for the facility." Review of the minutes for the Resident Council meetings, dated 01/31/19, 02/2019, and 03/14/19, indicated none of the three (3)documents contained information related to the location of the state agency's survey results, or of the residents' right to be able to access and review the survey results without the assistance of the staff. Observation of the facility's lobby area on 03/26/19 at 10:30 AM, revealed a binder labeled, "Survey Inspection Results" on a table near the front entrance, which contained the results of the facility's most recent state agency survey and plan of correction. During the Resident Council Interview on 03/26/19 at 9:00 AM, which was attended by Resident #5, Resident #10, Resident #14, Resident #22, Resident #33, Resident #48, Resident #72, and Resident #76, the group expressed concerns related to not knowing the location of the state survey results, or of their right to view the survey results without staff	M 500	On April 5, 2019, Resident #10 received Residents Rights Information and location of survey results. On April 4, 2019, Resident #14 received Residents Rights Information and location of survey results. On April 5, 2019, Resident #22 received Residents Rights Information and location of survey results. On April 4, 2019, Resident #33 received Resident Rights Information and location of survey results. On April 3, 2019, Resident #48 received Resident Rights Information and location of survey results. On April 4, 2019, Resident #72 received Resident Rights Information and location of survey results. On April 11, 2019, Resident #76 received Residents Rights Information and location of survey results. 2. All residents have the potential to be affected by failing to ensure that they are informed of the location of the facility 's most recent survey results and plan of correction. 3. On April 1, 2019, Social Services staff were in-serviced, by the Administrator, on ensuring residents have received knowledge to include the updated Resident Rights information and location	

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M 500	Continued From page 5 assistance. The group also expressed this was a topic not covered at previous Resident Council meetings. When asked if the state's inspection results were available to read all stated, "No." Resident #72 then stated, "We wouldn't know where they are posted." Resident #5 stated, "No one has ever mentioned anything about the state inspection results or where those may be." Resident #14 stated, "That would be nice to know as a resident here, so we are informed of what the outcome was. But we wouldn't even know where to review that information." Resident #22 stated, "We didn't know that we could ask for that information." Resident #72 stated, "No one has ever mentioned anything about that. I don't know where the information is." During an interview on 03/26/19 at 10:26 AM, Social Worker (SW) #1 stated, "Regarding the state survey inspection results, we have the survey book located where they first come into the facility. It's not brought up in every resident council meeting." When asked how the residents are informed of their right to review the state survey results and the location of those results, Social Worker #1 stated, "I'm not sure we are doing that. I know they get a resident rights book when they first come in." During an interview on 03/27/19 at 10:55 AM, the Director of Nursing (DON) stated, "Other than having our [survey results] book at the front, I don't think there is anything we give them [the residents] or really update or inform them of the state survey results. I think we need to find out a way to make sure we review it more often in Resident Council." During an interview on 03/27/19 at 11:20 AM, the Administrator stated, "We always tell families and	M 500	of survey results. Social Services will initiate review of Resident Rights information with quarterly care conferences and for all new admissions. 4. The Administrator will monitor the admissions process and quarterly care conferences beginning April 1, 2019, to ensure inclusion of Resident Rights information weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Administrator to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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M 500	Continued From page 6 residents upon admission that the survey binder is at the front door. In general, if someone asks, 'Where is the survey book?' we can tell them." When informed of the residents' concerns regarding the location of the state survey results for the facility and their right to review the results, the Administrator stated, "It is what it is, and we can fix it." B. Review of the facility's brochure titled, "A Matter of Rights - A Guide to Your Rights and Responsibilities as a Resident, which the facility provides to residents upon admission indicated on page 13, "Residents have the right to contact information for state licensing and advocacy groups, including: the State Survey Agency . . . the State Senior Protection and Advocacy Agency, the Aging and Disability Resource Center, and [the] Medicaid Fraud Control Unit." Review of the facility's undated policy titled, "Grievance/Complaints Policy," indicated the residents, "may file a written complaint to the local Ombudsman's office or to the state health department." Review of the facility's last three (3) months of Resident Council "Meeting Minutes," dated 01/31/19, 02/2019, and 03/14/19, revealed no documentation to indicate the residents were provided with information on how to make a formal complaint to the State Agency, or information regarding Advocacy groups. During the Resident Council Group meeting, held on 03/26/19 at 9:00 AM, residents were asked if they have been informed of, and provided information on how to file a formal complaint to	M 500		

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M 500	Continued From page 7 the State Survey Agency about the care they receive. Resident #33 stated, "No." Resident #14 stated, "I could probably figure that out on my own. I would probably just get on the phone and start calling people until you get through to the right agency, then get the right person I guess." Resident #5 stated, "I guess I would just go to the Resident Council President and try to get our problems straightened out together. I wouldn't know of how to contact our state if I needed to. That has never been mentioned to us." Resident #33 stated, "I don't really know what the process is or how to go about making a complaint to the state or contacting any other agencies. That is something we haven't been told about." Resident #72 stated, "I wouldn't even know where to start. That is something that we haven't been told about- who to call or what the process is." Resident #76 stated, "Me as well. I wouldn't know." Resident #22 stated, "We have never been given that information and that isn't something we have covered either." Resident #10 stated, "No one ever reviews that information with us of who to contact. No in deed." Resident #48 stated "No." Resident #14 then stated, "I would hope if anyone had a problem, we could get it worked out before going to the state." Resident #22 stated, "It would be nice to know that information if I ever needed to contact someone at the state or any other agency." During interview on 03/26/19 at 10:26 AM, Social Worker (SW) #1 stated, "Well, usually with any kind of situation, we call the Ombudsman and she helps us anytime we have a concern. We just verbally let them [the residents] know that they have rights, and they can contact the Ombudsman or the state [State Survey Agency] if they want to, but it has just been done verbally. Other than that, it's posted of who to contact."	M 500		

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M 500	Continued From page 8 When asked if the residents receive any information on the process of contacting other advocacy agencies, or on the process of contacting the state if needed, Social Worker #1 stated, "They might get something in admissions. Not that I'm aware of anytime after that. Not that I'm aware of where residents would know how to go directly to the state agency." During a second interview on 03/27/19 at 9:00 AM, Social Worker #1 stated, "We don't review the state complaint information in every meeting. As far as routinely, we don't bring it up in every meeting. They get a resident rights book on admission. If I had a situation where I would need help, I would contact the Ombudsman, then she would come to explain the process. If there was a concern, I guess I would have to give them the information that is posted at the front lobby area." When asked how the facility informs the residents of their right to contact the State Survey Agency, Social Worker #1 stated, "We don't review it in every meeting . . . It's not something I review with them. We just know the information [contact information for the State Survey Agency and the Ombudsman Program] is there [posted on the wall in the front lobby] and if we need it, we can get it for them." During an interview on 03/27/19 at 10:55 AM, the Director of Nursing (DON) stated, "On admission they [the residents] get some information on the State Survey Agency, then if there is a grievance, if we can't handle it, we would go to the Ombudsman. If they [the residents] are not happy with the Ombudsman, then I would let them know what the different layers are to go through, such as the Administrator or our Licensure and Certification State Agency." When asked how this information is communicated to the residents, the	M 500		

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M 500	Continued From page 9 DON stated, "I think it would be by the posting on the wall, and they are given a booklet on admission. For now, we are not enforcing that information like the phone numbers to call, and who to contact. We don't routinely let them know of the State Agency, or a phone number to call, or any other agencies." When asked for the reason, the DON stated, "There really is no reason; we need to let the residents know that these are the proper agencies to contact if you need to. They need to be made aware of those options on a regular basis." During an interview on 03/17/19 at 11:20 AM, the Administrator stated, "On admission, we let people know and [also] in Resident Council. I know our Ombudsman tells them if you have any issues, you can call the state agency as well. If they [the residents] were to come to us and say 'I want to call' [the State Survey Agency], then we would give them the numbers. Our Social Workers are the ones that would ensure that information gets communicated to the residents."	M 500		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed.	M 735		4/28/19

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M 735	Continued From page 10 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full	M 735		

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M 735	Continued From page 11 name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and review of facility policy, the facility failed to develop comprehensive person-centered care plans for two (2) residents, Resident #86 and Resident #36), out of a sample of 22 residents. The staff failed to include the use of antidepressant medication on the care plan for Resident #86, and failed to include resident-specific interventions for repositioning on the care plan for Resident #36. Findings include: On 03/28/19 at 11:22 AM, the Director of Nursing (DON) provided a written statement to the survey team that read, "[Name of facility] does not have a policy for comprehensive care plan completion." Resident #86: Review of Resident #86's care plan, initiated on 02/20/19, indicated it did not include a care plan problem, goals, or interventions related to the resident's use of antidepressant medication. Review of Resident #86's "Physician Order Summary Report," which included the resident's "Active Orders" for 02/19/19 through 03/28/19, revealed orders for Sertraline HCL (an antidepressant medication), 100 milligrams (mg) one (1) time a day for the diagnosis of "Depression," Trazodone HCL (an antidepressant medication), 25 mg one (1) time a day for "Depression" plus Trazodone HCL, 75 mg one (1) time a day at 8:00 PM for "Depression/Agitation." Further review of the "Physician Order Summary	M 735	1. On April 5, 2019, a comprehensive care plan to include triggered Care Area Assessments (CAA) was completed for Resident #86 by the Minimum Data Set Coordinator. On March 28, 2019, the sacral ulcer care plan for Resident #36 was revised by the Director of Nursing to include resident individualized intervention to assist with repositioning/off-loading while in wheelchair. 2. Residents with comprehensive care plans have the potential to be affected by failure to develop comprehensive person-centered care plans. 3. On April 1, 2019, the facility Administration developed a policy for Comprehensive Care Plans. On April 5, 2019, Minimum Data Set licensed nursing staff were in-serviced by the Administrator on the revised Base Line Care Plan Policy and the Comprehensive Care Plans Policy. 4. The Director of Nursing or Assistant Director of Nursing will monitor admission comprehensive care plans to ensure they are complete as compared to Care Assessment Area triggered care plans beginning April 1, 2019, to ensure they are complete and a copy provided to resident/family, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 735	Continued From page 12 Report" revealed additional orders, which directed the staff to monitor the resident for the occurrence of side effects of antidepressant medications, for episodes of behaviors/mood disturbance, and for the outcomes of the interventions implemented during episodes every shift. Review of Resident 86's admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 02/26/19, indicated the facility admitted the resident on 02/19/19, with diagnoses that included Depression. The MDS specified the resident had a "Brief Interview for Mental Status (BIMS)" (a cognitive ability assessment tool) score of 00 out of 15, which indicated he had severe cognitive impairment. The assessment also indicated Resident #86 received antidepressant medication on all seven (7) days of the assessment's seven-day look-back period. Review of the "Care Area Assessment (CAA) Summary" section of the admission MDS, indicated the answers documented in the assessment triggered the care area, or "CAA," for "Psychotropic Medication Use." Further review of the "CAA Summary" indicated the staff would address Resident #86's use of antidepressant medication in his care plan. Review of Resident #86's subsequent 14-day MDS with an ARD of 03/04/19, also indicated the resident received antidepressant medication on all seven days of the assessment's seven (7)-day look-back period. Review of Resident #86's EMR revealed a "Medication Administration Record (MAR)" for March 2019, which indicated the resident received Sertraline HCL 100 mg daily at 9:00 AM,	M 735	Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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	69SC	A. BUILDING: _____ B. WING _____	03/28/2019

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M 735	Continued From page 13 Trazodone HCL 25 mg daily 9:00 AM for "Depression," and Trazodone HCL 75 mg daily 8:00 PM for "Depression/Agitation." During an interview on 03/28/19 at 11:05 AM, Licensed Practical Nurse (LPN) #3 stated, "[Resident #86] is getting Trazadone 75 mg at night for 'Depression/Agitation' and Trazodone 25 mg in the morning. He is also getting the Sertraline 100 mg a day for depression. We do monitor [Resident #86] for side effects every shift." When asked if there was a care plan for the use of the antidepressants, LPN #3 stated, "All I see is a care plan to maintain current level of function to be symptom free of dehydration. I don't see one for the medications." During an interview on 03/28/19 at 11:11 AM, the Director of Nursing Assistant stated, "There should be a care plan [for Resident #86]. We should have a psychotropic medications care plan. We do monitor for side effects, for changes in behavior type, the interventions done [sic], and the outcomes [of the interventions]. . . . we should have a care plan for this." When asked when a care plan should be developed, the Director of Nursing Assistance stated, "We get a baseline care plan within 72 hours, but we should also have a comprehensive care plan [for Resident #86] and I'm not seeing one." During an interview on 03/28/19 at 11:22 AM, the DON stated, "On [Resident #86's] admission MDS dated 03/04/19, and on the 14-day MDS dated 02/26/19, Section N [for] antidepressant [medication] is marked 'yes' as being received in the last seven days." When asked if Resident #86 had a care plan for the use of the antidepressants, the DON stated, "I'm guessing we don't have a care plan. We should have one	M 735		

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M 735	Continued From page 14 for the antidepressants." When asked about the process for developing a comprehensive care plan, the DON stated, "From the time of admission, we note the physician's orders [and] get the consents [for psychotropic medication administration]. . . . By day 21, we should have a care plan for every 'CAA' that triggered." When asked if there was a comprehensive care plan for behaviors, the DON stated, "No. . . . [the] MDS is the starting point for the care plans, starting with the [triggered] CAAs. I would have to ask the MDS person why the care plan was not completed." During an interview on 03/28/19 at 11:53 AM, the MDS Assistant stated, "On [Resident #86's] admission MDS, on Section N, I see antidepressant checked and that the resident received it in the last seven-day look-back period. On Section V, the CAA worksheet says he is at risk for side effects for [sic] antidepressant meds, proceed to care plan." When asked if Resident #86 had a comprehensive care plan, the MDS Assistant stated, "I don't see one. I'm sorry, I didn't develop one. . . .There should be a care plan for the antidepressant medications. I can't say why [it was not done]. He is getting the medications for depression and agitation and there should be a comprehensive care plan [for use of those medications]." Resident #36: Review of Resident #36's Care Plan, initiated on 01/04/19, indicated the staff were directed to, "Encourage turning and repositioning while in bed and discourage extended periods of sitting up." The care plan did not include resident-specific time frames for repositioning Resident #36, based on an assessment of the resident's unique risk factors for skin impairment.	M 735		

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M 735	Continued From page 15 Observation on 03/25/19 from 9:00 AM to 9:15 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing outside the Rehabilitation Area. During the observation, Resident #36 did nothing to change his position and no staff intervened to encourage, or prompt him to change his position. Observation on 03/25/19 from 10:03 AM to 11:00 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. Observation on 03/25/19 from 12:04 PM to 1:30 PM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. Observation on 03/25/19 from 2:30 PM to 3:15 PM, revealed Resident #36 sat in his wheelchair in the dining room. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. Observation on 03/26/19 from 10:38 AM to 11:15 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. During an interview on 03/26/19 at 9:01 AM, Resident #36 stated that about two (2) years ago he developed a spinal infection that left him with	M 735		

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M 735	Continued From page 16 very little sensation from the waist down. After a previous stay at this facility, Resident #36 stated he was able to return home with his wife serving as his primary care giver. However, at home he developed two (2) pressure ulcers in his sacral (lower back) region, which quickly worsened. When asked how often the staff assisted him with position changes throughout the day, Resident #36 stated, "Not as much as I should [be repositioned] . . . When I ask for help with repositioning, they will help me out of my wheelchair and help me into bed . . . When they help me to bed during the day to change my position, I stare at the ceiling and the four (4)walls and it gets me down. I prefer to be out with the people, going outside with my wife, and going to activities, especially music performances. So, I don't ask for help with repositioning." Resident #36 stated that he can lift himself in his wheelchair to relieve the pressure on his back, but forgets to do so, and added, "I think that would help if staff reminded me [to change positions] and didn't take me to bed." Review of Resident #36's admission MDS, with an ARD of 01/10/19, specified the resident had a BIMS score of 15 out of 15, which indicated he had no cognitive impairment. The assessment indicated Resident #36 exhibited no episodes of rejection of care, and that his "Skin and Ulcer Treatments" included being placed on a turning and repositioning program. During an interview on 03/26/19 at 10:43 AM, Certified Nursing Assistant (CNA) #6 stated that Resident #36 can ask for repositioning during the day and the staff will help him back to his bed. She added that Resident #36 can also reposition himself by raising up in his wheelchair.	M 735		

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M 735	Continued From page 17 During an interview on 03/26/19 at 2:00 PM, Licensed Practical Nurse (LPN) #4 stated that Resident #36 sits in his wheelchair for extended periods of time each day and added, "He can ask to go lay on his bed during the day, but he usually doesn't ask to return to his room." During an interview on 03/27/19 at 2:00 PM, the Rehabilitation Director reported that Resident #36 is seen in therapy every day, and that therapy staff work with the resident on rising from his chair and walking short distances. The Rehabilitation Director then stated, "As to his motivation, I am concerned that he seems so withdrawn and so flat most of the time, but he is willing to do whatever we ask of him." She added that Resident #36 knows to use his arms to press down on the arms of his wheelchair to raise his back and bottom off the wheelchair seat, but she was not sure how often he completed this maneuver throughout the day. She stated it would be better for relieving pressure from his back and bottom if he could be assisted to stand and walk at regular intervals when he is up and around during the day. She said she believed this change could be accomplished with some coordination between the nursing and rehab. During interviews on 03/26/19 at 3:43 PM, and on 03/28/19 at 11:12 AM, the DON stated that Resident #36's repositioning needs could be better met with a change to his care plan to include specific requirements for position changes throughout the day.	M 735		

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	69SC	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**03/29/2019**

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on observations and testing the facility failed to achieve the required transfer time of 10 seconds when testing the generator in accordance with NFPA 110 Chapter 4, Table 4.1 (b) & 4.3 Type. This condition has the potential to affect 100% of the residents and staff. Findings include: On March 29, 2019 at, 10:50 AM, the generator had a failed test of transferring power to the facility within the required 10 seconds. The tested transfer time was recorded at 19.57 seconds. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	M1245	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On 4/2/19, Thompson Power (generator vendor) noted a damaged 4 pole breaker in transfer switch box and investigated the cause of the delay in power transfer to facility and stated "the failure is commonly caused by an electrical surge to these control components and recent local area history confirms that possibility." 2. Due to the nature of the deficiency, all facility residents have the potential to be affected. 3. The facility Administrator provided education to Maintenance Director related to documentation of staff audits on the education and return demonstration of	5/28/19

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M1245	Continued From page 1	M1245	transferring power. On 4/1/19, the Maintenance Director in-serviced staff across all shifts how to manually transfer power in the event of a power failure that required the generator to engage along with return demonstration. A new 4 pole breaker was ordered 4/9/19 and insurance company was notified. 4. The facility Administrator will audit the weekly staff audits beginning April 1, 2019 weekly for (4) weeks, then monthly for (2) months to ensure compliance with the standard. Audit findings will be submitted to facility Administrator on a weekly basis and will be submitted to the Quality Assurance Committee for review and recommendations for (3) months.	