STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING _____ B. WING _____	04/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

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F 000	INITIAL COMMENTS A Recertification Survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health, at the facility from 4/15/19 to 4/19/19. In conjunction with the Recertification Survey, Complaint Intake MS00015816 related to Quality of Care was investigated, and found to be unsubstantiated with no deficiencies cited. During the survey, the facility was found not to be in substantial compliance with the requirements of participation for Medicare and Medicaid. The facility was cited regulatory deficiencies at F582, F584, F661, and F755. The facility's census on 4/15/19 was 70 residents, and the facility held a license for 90 beds.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		5/31/19

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

Electronically Signed | 05/28/2019

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F 582	Continued From page 1 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on document review, interview and, policy review, the facility failed to ensure three (3) of three (3) sampled residents Residents #118, #119 and #120, of the six (6) residents discharged from the facility with Medicare part A days remaining	F 582	Tag 0582-Medicaid/Medicare Coverage./Liability Notice 1) Resident #118, #119 and #120 have been discharged home and are no longer	

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F 582	Continued From page 2 received the required notices of the end of Medicare covering the facility services. Findings include: Review of the facility's "Traditional Medicare Beneficiary Notices for the SNF [Skilled Nursing Facility]" policy, last revised 03/2019, revealed the facility is required to notify beneficiaries of their right to a review process when the SNF anticipates Medicare coverage of their services will end. The SNF must provide the beneficiaries the notice no later than two (2) days before the end of the Medicare covered services. Review of the "Beneficiary Notice" provided by the facility, for Resident #118, revealed an admission date of 09/24/18 for Medicare skilled services. Resident #118 was discharged on 11/20/18. The notice was signed by the Administrator on 11/22/18, two days after was discharged Review of the "Beneficiary Notice" provided by the facility, for Resident #119, revealed an admission date of 01/08/19 for Medicare skilled services. Resident #119 was discharged on 03/08/2019. The notice was signed by the Administrator, on 03/11/19, three days after Resident #119 was discharged. Review of the "Beneficiary Notice" provided by the facility, for Resident #120, revealed an admission date of 01/18/19 for Medicare skilled services. Resident #120 was discharged on 02/06/19. The notice was signed by the Administrator on 02/08/19, two days after Resident #118 was discharged.	F 582	in the facility. Social Services have followed up with residents after discharge and the residents are doing fine at home with no problems. 2) All residents being discharged with Part A days remaining have the potential to be affected by this alleged deficient practice. 3) Medicare Nurse Case Manager, Social and the Assessment Nurse involved with Medicare discharges have been in-serviced on policy Discharge Transfer and Planning policy on April 23, 2019, by the Director of Nurses. To assure all discharges with Medicare Part A days remaining are notified timely, the Administrator, Director of Nurses, Social, Medicare Nurse Case Manager, Accounts Manager and the Assessment Nurse will review all Medicare Part A discharges in our Daily Stand Up meeting beginning April 23, 2019. The facility Quality Assurance Committee, which included the Administrator, Director of Nurses, Medicare Nurse Case Manager, Assessment Nurse, Medical Records, Social and the Medical Director met on April 16, 2019, and reviewed policy and procedure Discharge Transfer and Planning policy. Discharge information will be reviewed by the Director of Nurses weekly times four weeks, then monthly times three months and then quarterly to ensure there are no further concerns. The Director of Nurses and the Interdisciplinary Team will report any concerns to the Quality Assurance	

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F 582	Continued From page 3 Interview with the Accounts Manager, on 04/17/19 at 12:14 PM, revealed she was not informed of residents who are receiving Medicare provided services are discharged until approximately two days after they have been discharged. Interview with the Administrator, on 04/17/19 at 1:53 PM, confirmed the notices were not given at least two (2) days prior to discharge, as required.	F 582	Committee. 4) The Interdisciplinary Team and Director of Nursing will report any concerns to the Quality Assurance Committee quarterly. If problems are identified with current corrective action plan, the Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		5/31/19

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F 584	Continued From page 4 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure the building was free from strong odors of urine and feces in two (2) of four (4) hallways. Findings include: During an interview with the Director of Nursing (DON), on 04/18/19 at 5:05 PM, the DON stated the facility did not have a policy related to keeping blue laundry containers less than 3/4 full but her expectation would be that the containers are emptied when there is a strong odor of feces and/or urine. Observations made during the initial tour of the facility, on 04/15/19 at 7:05 PM, revealed the North Main hallway of the facility had a strong odor of urine and feces and remained in the area until 9:30 PM (approximately two and a half hours).	F 584	Tag 0584- Safe Clean/Comfortable/Homelike Environment 1) Odors in the North Main hallway and the North Wing hallway have been eliminated. The rooms have all been deep cleaned. The linen barrels have been washed. 2) All residents have to potential to be affected by this alleged deficient practice. 3) Housekeeping and laundry were in-serviced on May 8, 2019 on how to deep clean correctly and given a new cleaning schedule by the Housekeeping/Laundry Supervisor. Housekeeping deep cleaned all rooms on both hallways beginning April 23, 2019 to May 3, 2019. They will deep clean rooms per schedule along with routine cleaning per their assignments. Housekeeping	

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F 584	Continued From page 5 Observations conducted in the North Main hallway, on 04/16/19 at 07:15 AM, revealed the area had a strong odor of urine and feces. Additional observations, conducted on 04/16/19 at 12:32 PM, revealed the North Main hallway continued to smell of urine and feces. Observations conducted, on 04/18/19 at 4:10 PM, revealed the North Wing hallway had a large, blue laundry container with a lid covering the container. The North Wing hallway had a strong odor of urine and feces. During an interview with Licensed Practical Nurse (LPN) #2, on 04/18/19 at 4:22 PM, LPN #2 stated the odor of feces was noticeable. LPN #2 stated there was, "a strong smell of urine odor in the hallway even with the lid of the large blue bin being closed." Interview with the Environmental Services Director, on 04/18/19 at 4:30 PM, revealed the Environmental Services Director was unsure if there was a facility policy related to eliminating strong odors of feces and urine from the building. The Environmental Services Director stated his expectation was that housekeeping staff should keep the facility in a sanitary condition, and free from odors of feces and urine. Interview with the Administrator, on 04/18/19 at 4:57 PM, revealed the laundry containers should be emptied prior to the containers becoming, "3/4 full." The Administrator further stated if a strong smell of odors were noticeable to staff prior to the container being three fourth (¾) full, it was her expectation the containers should be emptied to keep the facility free from odors of urine and feces.	F 584	cleaned all linen barrels and will clean them each week. New linen bags will be placed in the barrels by laundry daily or as needed. Staff Development in-serviced the Certified Nursing Assistants on May 16, 2019 to empty dirty linen barrels at three fourths full and keep lids on tightly in halls to keep the risk of odors down. The Housekeeping/Laundry Supervisor will monitor rooms and hallways for odors with staff daily beginning April 23, 2019. The Administrator and Director of Nurses will check the rooms and hallways for odor on normal rounds. Any problems will be reported to Housekeeping/Laundry Supervisor. She will report any problems to the Quality Assurance Committee. 4) The Administrator will report to the Quality Assurance Committee quarterly. The Quality Assurance Committee will monitor quarterly and make revisions and/or corrections when needed.	

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F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a discharge summary was completed for one of three sampled residents, Resident #70, whose clinical record was reviewed for discharge. A total of six (6) residents had been discharged during the past six (6) months.	F 661	Tag 0661-Discharge Summary 1) Resident #70 remains discharged from our facility. Follow up was done by the Social Service Director and is doing well at home.	5/31/19

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F 661	Continued From page 7 Findings include: The facility's "Discharge Transfer and Planning" policy and procedure, last reviewed 04/2018, documented: "The Electronic Discharge/Transfer Summary shall be completed on the day of discharge." Review of Resident #70's "Face Sheet" indicated the resident had been admitted by the facility, on 12/21/18, with diagnoses which included Essential Hypertension and Diabetes Mellitus Type II with Diabetic Neuropathy, Generalized Intractable Epilepsy, and Peripheral Vascular Disease. The resident's "Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 12/28/18, was reviewed. It documented the resident had a Brief Interview for Mental Status (BIMS) (a cognitive evaluation) score of 15 out of 15, which indicated he was cognitively intact as well as indicated Resident #70 received speech therapy, occupational therapy and physical therapy during the seven days prior to the ARD. The care plan, dated 12/21/18, documented the resident had a plan for discharge to the community. Appropriate goals and interventions were addressed. A physician's order, dated 01/17/19, documented the resident was to be discharged to home with family, medications and narcotics on 01/18/19. The order documented Resident #70 was to follow up with physicians as needed. It documented the resident had refused home health services.	F 661	2) All discharged residents have the potential to be affected by this alleged deficient practice. 3) The Medicare Nurse Case Manager, Social and Assessment Nurse involved with discharge of a resident have been in-serviced by the Director of Nurses on April 23, 2019 on the policy Discharge Transfer and Planning. All admissions and discharges will be monitored during the daily stand up meeting Monday through Friday beginning April 23, 2019, by the Interdisciplinary Team to assure all discharge assessments are done. Any concerns will be reported weekly for four weeks then monthly for two months and then quarterly after to the Quality Assurance Committee. 4) The Interdisciplinary Team will report to the Quality Assurance Committee quarterly. The Quality Assurance Committee will monitor quarterly and make any revisions and/or corrections when needed until substantial compliance has been achieved.	

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F 661	Continued From page 8 A nurse's note, dated 01/18/19 at 8:55 AM, documented the resident went home with family and took his medications and belongings. Resident #70's clinical record contained no discharge summary, including a recapitulation of his stay at the facility. On 04/18/19 at 5:24 PM, the Medical Records Supervisor stated no discharge summary had been completed for the resident. On 04/19/18 at 8:58 AM, the MDS Coordinator stated the facility's policy and procedure to complete the discharge summary had not been followed.	F 661		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		5/31/19

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F 755	Continued From page 9 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to acquire pain medication in a timely manner, as well as well as ensure documentation of "as-needed" (PRN) medication included justification and response to the effectiveness of the medication for one of three (1 of 3) sampled residents, Resident #48, whose clinical records were reviewed for pain management. Findings include: Review of the facility's "Drug Administration and Documentation" policy, revised 11/2017, documented: "Chart each resident's medications on the MAR [Medication Administration Record] immediately after it is administered, PRN [as needed] medications will be documented on the MAR and the reason for giving as well as the result/response for each dose given will be noted in the clinical record." The facility's, "Pain Screen and Management", policy and procedure, revised 09/2018, documented: "When the resident is medicated	F 755	Tag 0755- Pharmacy Services/Procedures/Pharmacist/Records 1) Resident #48 received his pain medication Percocet on April 16, 2019. The physician was notified on April 16, 2019 that the medicine was given late. 2) All residents receiving pain medication have the potential to be affected by this alleged deficient practice. 3) The Licensed Practical Nurse who failed to follow the pharmacy after hours procedure was in-serviced on April 16, 2019 by the Director of Nurses on how to obtain prescriptions after hours and on weekends. Licensed Nurses were in-serviced on Pain Management and after hour pharmacy procedures on April 25 & 26, 2019 and May 2 & 23, 2019 by the Director of Nurses and the Staff Development Licensed Nurse. The medication administration record for all residents receiving pain medication has	

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F 755	Continued From page 10 with prescribed medication or treated as ordered, documentation of medication or treatment is done on the Medication Administration Record (MAR). Documentation, using the pain scale, of a new type of pain, a pain medication and/or treatment change, is done every shift until the pain is managed effectively. Documentation includes location of pain, medication given and its effect using the pain scale plus any concerns about side effects." Record review revealed Resident #48 was admitted by the facility, on 01/10/19, with a diagnosis including but limited to pain. The resident's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/17/19 and 04/06/19, documented the resident had a "Brief Interview for Mental Status (BIMS) (a cognitive evaluation) score of 15 out of 15, which indicated he was cognitively intact. The MDS also documented Resident #48 had pain in right hip and pain in unspecified upper arm and had frequent pain at a level of eight (8) of 10. The resident was coded as had received opioid medication on seven of seven (7 of &) days prior to the ARD. Review of the care plan, dated 01/10/19, documented Resident #48 had a problem related to his potential for pain and scheduled pain medication. Interventions for the problem included the charge nurse would "observe onset, location, severity, and duration of pain", and the charge nurse would observe the effectiveness of the medication. 1. Further review revealed a "Nurse's Note," dated 04/13/19 at 2:59 PM, documented Resident	F 755	been audited five times a week beginning April 23, 2019. These will be audited five times a week until all issues have been resolved, then weekly for one month and monthly for three months. The Director of Nurses will bring any problems to the Quality Assurance Committee. 4) The Director of Nurses will report to the Quality Assurance Committee quarterly. The Quality Assurance Committee will monitor quarterly and make revisions and/or corrections when needed until substantial compliance is achieved.	

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F 755	Continued From page 11 #48 had complained he was in "too much pain, [medications] not helping." The note documented the physician was called and ordered the resident be sent to the emergency room. During an interview with Resident #48, on 04/16/19 at 8:11 AM, he stated he had gone to the emergency room for severe pain on 04/13/19, and was given a prescription for Percocet which had not been filled yet. Interview with Licensed Practical Nurse (LPN) #1, on 04/16/19 at 9:24 AM, revealed LPN #1 stated there was a prescription for Percocet 5 milligram (mg) by mouth every six hours prn pain, which Resident #48 had been given at the emergency room on 04/13/19, that had not been filled. She stated the pharmacy was trying to get the prescription to the facility at that time. On 04/16/19 at 9:50 AM, the above findings regarding the unfilled prescription were reviewed with the Director of Nursing (DON). She stated the facility's policy and procedure for acquiring medications was to call the pharmacy provider in Jackson, Mississippi and give them the verbal order. She stated the facility has an emergency pharmacy in town that can also be utilized. The DON stated the resident should not be waiting for the prescription to be filled. She stated the emergency pharmacy in Clarksdale closed at noon on Saturdays and the facility had no way to get pain medication except to send the resident to the emergency room. She stated the facility did not have a way to acquire medications after hours and on weekends. She acknowledged Resident #48's prescription for Percocet received 04/13/19 at 6:14 PM, from the emergency room physician, had not been filled as of this interview. The DON	F 755		

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	255267	A. BUILDING _____ B. WING _____	04/19/2019

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F 755	Continued From page 12 stated the prescription should have been filled on 04/15/19 when the pharmacy was open. On 04/16/19 at 11:20 AM, the facility's Medical Director stated, "I certainly would expect the facility to get a [prescription] filled more promptly. On 04/16/19 at 2:19 PM, Resident #48's attending physician was interviewed by phone. In regard to the resident's Percocet prescription not being filled, the Physician stated, "I would expect a prescription to be filled the next day." On 04/16/19 at 2:39 PM, the Registered Pharmacist (RPh) from the facility's pharmacy provider in Jackson, MS, stated he was aware of the situation with Resident #48's Percocet prescription. He stated the nurse had faxed the prescription to the pharmacy after hours and had not called the pharmacy provider to inform them a prescription had been sent. The RPh stated no one works at the pharmacy on Sunday so the prescription was not found until Monday morning. He stated, had the nurse called the pharmacy regarding the prescription, a backup pharmacy in Clarksdale would have been called to supply enough medication to last until the full prescription amount could be sent out from Jackson. On 04/16/19 at 3:27 PM, Registered Nurse (RN) #3, was asked for the policy and procedure for acquisition after hours and on weekends. She stated there was no written policy and procedure. She stated nursing staff knew to call the pharmacy to obtain medication after hours and on weekends. She acknowledged the nurse who worked the evening of 04/13/19 did not know the procedure, and she had been in-serviced that	F 755		

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F 755	Continued From page 13 day. On 04/16/19 at approximately 3:45 PM, the Administrator provided a statement, signed by herself, on facility letterhead which documented: "April 16, 2019. To Whom It May Concern, Our facility does not have a written policy for the acquisition of any medications after hours." 2. Review of the "Physician Order", dated 02/06/19, documented the resident was to be administered Oxycodone 5 mg by mouth every six hours as needed for pain. A "Physician Order," dated 04/08/19, documented the resident was to be administered Oxycodone 5 mg by mouth every 12 hours as needed for pain. Review of the "Medication Record", dated 02/2018, revealed three of the 54 doses had been documented as administered, as well as the reason and the effectiveness of the medication. The "Medication Record," dated 03/2019, revealed none of the 92 doses administered had a documented reason as well as the effectiveness of the medication. The "Medication Record," dated 04/2019, revealed none of the 45 doses administered had a documented reason as well as the effectiveness of the medication There was no documentation which indicated the resident's pain had been assessed prior to the administration of the oxycodone, as well as there was no documentation which indicated the effectiveness of the pain medication after administration.	F 755		

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F 755	Continued From page 14 On 04/19/19 at 8:42 AM, the DON confirmed there was no documentation on the "Medication Record" which indicated the resident had been monitored/screened for pain every shift. The DON stated the nursing staff had not followed the facility's "Drug Administration and Documentation" policy and procedure for the administration of PRN pain medication. She stated the nursing staff had not documented the reason for the administration of the oxycodone, nor had they documented the effectiveness of the medication on the back of the "Medication Record." The DON further stated the facility's "Pain Screen and Management" policy and procedure had not been followed for the documentation of pain/pain medication.	F 755		

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	255267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2019**

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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 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and testing the fire alarm system, the facility failed to provide automatic sprinkler system supervisory signals in accordance by NFPA 101 Chapter 9.7.2.1, NFPA 72 Chapter 17.12.2. The deficient practice affected seven (7) of seven (7) smoke compartments and all 69 residents in facility on the day of survey. Findings include: During testing on April 16, 2019 at 10:25 AM, observation revealed the initiate of the fire sprinkler system (via inspector test valve) did not activate the fire alarm system. The fire sprinkler system was incapable of activating the fire alarm	K 352	Tag 0352-NFPA 101 Sprinkler System-Supervisory Signals 1) The water flow switch was replaced by Giles Fire Protection Company on April 16, 2019. They tested the fire sprinkler system (via inspector test valve) and it activated the fire alarm system in thirty-five (35) seconds. 2) All residents on the day of survey had the potential to be affected by the same deficient practice. 3) Giles Fire Protection Company came on April 16, 2019 and replaced the water	4/17/19

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

Electronically Signed | 05/23/2019

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	255267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2019**

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K 352	Continued From page 1 system within the minimum requirement of 90 seconds. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on April 16, 2019.	K 352	flow valve to the fire sprinkler system. They tested the system after replacing the valve and the system activated the fire alarm system in 35 seconds. Maintenance checked the fire sprinkler system the same day and daily from April 17, 2019 to April 23, 2019 with activation of the fire alarm system sounding from thirty-two (32) to thirty-five (35) seconds. He will check the sprinkler system weekly for two months, bi-weekly for two months and then quarterly. Any problems will be reported immediately to Giles Fire Protection Company and the Administrator. Any findings will be reported to the Quality Assurance Committee. 4) The Maintenance Director and/or Administrator will report to the Quality Assurance Committee quarterly or as needed. The Quality Assurance Committee will monitor quarterly and make any corrections when needed.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/16/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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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.