STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	02/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE/P. O. BOX 198 DUNCAN, MS 38740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 02/21/19 to 02/23/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA cited deficiencies at F554, F623, F695, F758, and F880. The facility held a license for 60 beds, with a census of 57.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assess a resident, prior to allowing resident to self administer a hand-held inhaler for one (1) of four (4) residents observed during medication pass; Resident #47. Findings include: Per facility statement, dated 2/23/19, "There is not a policy and procedure for resident to self administer medications." A review of the physician's orders for Resident #47, dated February 2019, revealed an order for Ventolin HFA 90 micrograms (mcg) inhaler two (2) puffs by mouth three times a day (TID). On 02/22/19 at 09:26 AM, during an observation	F 554	"Preparation an/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is prepared and/or executed solely because it is required by provision of Federal and State Law." Resident Self-Admin Meds-Clinically Approp. CFR(s): 483.10(c)(7) Bullet 1. Corrective actions accomplished for alleged deficient practice:	4/10/19

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

Electronically Signed | 04/10/2019

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F 554	Continued From page 1 of medication pass for Resident #47, with Registered Nurse (RN) #1, the nurse handed the Ventolin Inhaler to Resident #47. Resident #47 immediately took three (3) puffs of the inhaler, with approximately one (1) second between each puff. An interview with RN #1, on 2/22/19 at 9:30 AM, revealed, she stated, Resident #47 did not get the correct dosage of the medication. RN #1 confirmed, she did not give the resident instructions on how to use the inhaler and that he had not been assessed for self administration of medications. On 2/22/19 at 9:49 AM, an interview with the Director of Nursing (DON), revealed, she stated, Resident #47 was not assessed to be able to self administer medications, and that he shouldn't have been given the inhaler to administer it himself.	F 554	A. On 2/22/2019 the Director of Nurses (DON)and Registered Nurse (RN)/ Medication Nurse assessed patient for any ill effects from the self administration of the Ventolin inhaler, no ill effects were noted. The Physician was called and notified of the error to allow patient to self administer Ventolin inhaler and no ill effects noted. Resident was assessed by RN Medication Nurse for ability to self administer using self assessment tool. Patient was unable to properly administer medicine. DON on 04/08/2019 reviewed Resident #47 suffered no ill effects at this time from failure to self administer medication as ordered by the Physician. B. All residents were interviewed on 2/28/2019 after resident council meeting for the choice to self administer medications. Five(5) residents have voiced a desire to self administer medicine and all Five(5) residents were assessed but all failed the assessment. C. Nurses do not allow Resident #47 to self administer medications (inhaler) as there is no Physician order to allow it. D. Pursuant to further review by Administrator, Self -Administration of Drugs Policy and Procedures was located in the Facility Policy and Procedure manuals. Bullet 2. All residents have potential to be affected by this deficient practice. A. All residents will be assessed upon	

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F 554	Continued From page 2	F 554	admission by the Admission Nurse and quarterly by a Care Plan Nurse to self administer medicine. Administration assessments to be completed on all who voices a desire. If a patient pass the assessment the Physician will be called for a written order pending Medical Director's decision. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. An in-service was held on 4/08/2019 regarding assessment of Self - Administration of Drugs with DON by Administrator. On 4/08/2019 resident #47 was re-assessed for self administration of medicine and failed the assessment. B. An in-service for DON and Nursing Staff was held on 4/09/2019 by a local Administrator, former DON/RN as to the importance of Self-Administration of Drugs. Bullet 4. DON is responsible to ensure compliance. DON will perform random interviews with residents to determine desire for self administration of medicines 1 X a week X 4 weeks starting 3/13/2019 then monthly X 3 months. DON will report findings to the Quality Assurance Committee (QA) monthly. The QA Committee will review interviews and outcomes of the assessment and determine the effectiveness of the assessment and implement revisions as needed.	

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F 623 SS=D	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 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	F 623		4/10/19

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F 623	Continued From page 4 (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 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.	F 623		

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F 623	Continued From page 5 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 record review and staff interview the facility failed to notify the resident's representative and the Ombudsman, in writing, of the resident's transfer to the hospital, for two (2) of two (2) resident records reviewed for hospitalizations; Resident #27 and Resident #30. Findings include: Resident #27 A record review for Resident #27, revealed Resident #27 was transferred to an acute hospital on 11/28/19. On 02/22/19, at 02:46 PM, in an interview with the Social Worker (SW), she stated that she does not notify the Ombudsman or Responsible Party in writing of hospital transfers and that she was not aware of the need to do this.	F 623	F623 Notice Requirements Before Transfer/Discharge CFR(s):483.15(c)(3)-(6)(8) Bullet 1. Corrective actions accomplished for alleged deficient practice: A. After further review by Administrator and Social Worker, a section of policy and procedures about Bed Hold, Transfers, and Discharges was located in Facility Policy Procedure Manuals. On 2/21/2019 thru 2/23/2019 Policy on Bed Hold, Transfers and Discharges was present in the facility. Administrator reviewed policy with Social Worker on 2/25/2019. This policy will be utilized to ensure no further deficiency occurs in this practice. B. Social Worker notifies Ombudsman	

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F 623	Continued From page 6 During an interview on 02/22/19, at 03:00 PM, with the Director of Nursing (DON), she stated, the facility does not notify the Responsible Party (RP) or the Ombudsman of hospital transfers or discharges in writing . She stated, the facility does not have a policy for notification of hospital transfers or discharges. Resident #30 A review of Resident #30's record, revealed Resident #30 was transferred on 12/11/18, to an acute hospital. Interview with the SW, on 2/22/19 at 02:46 PM, revealed she does not notify the Ombudsman or Responsible Party in writing of hospital transfers and was not aware of needing to do so. An interview with the DON, on 2/22/19 at 03:00 PM, revealed the facility does not notify the RP or Ombudsman of hospital transfers or discharges in writing. The DON revealed, the facility does not have a policy for notification of hospital transfers or discharges.	F 623	monthly of all discharges at the request of the Ombudsman by fax and will add all transfers to the list. C. Resident #27 and #30 has not been transferred or discharged since survey exited. D. On 2/25/2019 a transfer discharged audit was completed by Social Worker to ensure Bed Hold notices had been mailed. Bullet 2. All residents have the potential to be affected by the deficient practice of transfers and discharges without notice. A. Going forward a letter will be sent out to the Responsible Party (RP) and/or patient with all transfers, admissions and discharges. B. A conversation with local Ombudsman and state Ombudsman by Social Worker reveal requirements to send a monthly log of transfers and discharges. A monthly log will be faxed to the local Ombudsman and emailed to the state Ombudsman. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur. A. On 4/08/2019, Social Worker and Administrator were in-serviced by a local Administrator on the importance of proper notification to Ombudsman, Resident, and/or responsible party in writing upon	

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F 623	Continued From page 7	F 623	transfers or discharges. B. On 2/25/2019 Social Worker located in the facility and reviewed Policy and Procedures on Bed Hold, Transfer, and Discharges to ensure compliance with regulations. C. On 4/08/2019, Administrator in-serviced Director of Nurses on the Policy and Procedures for Bed Hold, Transfers and Discharges. D. State and local Ombudsman were called on 4/09/2019 regarding Policy and Procedure on Bed Hold, Transfer and Discharges log by Social Worker. Bullet 4. Social Worker is responsible to ensure compliance. Social Worker will monitor all transfers and discharges 5 X a week Monday thru Friday to ensure proper notifications. On Saturday and Sunday the Charge Nurse will complete a Bed Hold log in which the Social Worker will follow-up on Monday to ensure Bed Hold letter has been mailed. Findings will be reported to Quality Assurance(QA) committee on a monthly basis by the Social Worker. The QA Committee will evaluate the process and address the need for changes as concerns develops.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		4/10/19

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F 695	Continued From page 8 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to store oxygen tubing and a nebulizer mask in a manner to prevent contamination and likelihood of infection, for one (1) of 23 sampled residents; Resident #35. Findings include: An observation, on 02/21/19 at 10:38 AM, revealed Resident #35's nebulizer mask and oxygen cannula tubing lying on the bedside table and not stored in a bag. On 02/21/19 at 1:07 PM, an interview with Resident #35, revealed the staff does not put his oxygen tubing or nebulizer mask in a bag when not in use. Resident #35 stated, they do wash the nebulizer mask after he uses it. An observation, on 02/22/19 at 01:05 PM, revealed Resident #35's oxygen tubing and nebulizer mask in a plastic bag. An interview, on 02/22/19 at 01:15 PM, with Registered Nurse (RN) #2, confirmed Resident #35's oxygen tubing and nebulizer mask were not in a bag. She stated, she put it in a bag this morning. RN #2 confirmed, the oxygen tubing and	F 695	Respiratory/Tracheostomy Care and Suctioning CRF(s): 483.25(i) Bullet 1. Corrective action accomplished for alleged deficient practice. A. On 2/22/2019 Resident #35 was assessed by Registered Nurse(RN) and no ill effects noted. Nebulizer mask and tubing was cleaned, dated and stored in a bag. The bag per policy will be replaced every three days. B. On 4/08/2019 Resident #35 was assessed by the Director of Nurses(DON) for potential harm due to infection control issues due to Nebulizer mask and tubing. DON determined that Resident #35 suffered no ill effects at this time due to storage issues with Nebulizer mask and tubing. Bullet 2. All residents have the potential to be affected by this deficient practice. A. On 2/22/2019 all residents that utilize Nebulizer and oxygen supplies was assessed by RN with no ill effect found.	

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F 695	Continued From page 9 nebulizer mask should be stored in a plastic bag and dated. She further stated, this was an infection control issue because bacteria could get on it. An interview, on 02/22/19 at 01:58 PM, with the Director of Nursing (DON), confirmed the oxygen tubing and nebulizer masks should be stored in plastic bag, that is dated. She stated, they should be changed every three (3) days.	F 695	Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. On 4/09/2019, DON and Nursing Staff were in-serviced by a local Administrator and DON/RN on infection prevention an control with the use of Nebulizer mask and tubing. B. On 4/09/2019, Pharmacy Consultant in-serviced DON and Nursing Staff on infection prevention and control with the use of Nebulizer, Nebulizer mask and tubing. C. On 4/08/2019, DON in-serviced by the Administrator as to the importance of Infection prevention and control as it relates to Nebulizer supplies and storage of equipment. D. The DON will ensure compliance by making walking rounds and visual observations daily. Bullet 4. DON is responsible to ensure compliance. DON will monitor Nebulizer supplies (mask and tubing) 1 X a week for 4 weeks and then monthly to ensure proper storage and infection prevention methods are followed per facility policy. Findings will be reported to Quality Assurance (QA) Committee on a monthly basis by the DON. The QA Committee will review and evaluate findings for potential concerns and address changes as the needs develops.	

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		4/10/19

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F 758	Continued From page 11 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to initiate a stop date for psychotropic/ antipsychotic medications for one (1) of five (5) residents reviewed for unnecessary medications; Resident #27 Findings include: The facility did not have a policy for as needed (PRN) orders for antipsychotic and psychotropic medications limited to 14 days. A record review for Resident #27, revealed an order dated 2/16/19, for Haldol 10 milligrams (mg) intramuscularly (IM) now, Benadryl 50 mg IM now and Ativan 1 mg IM now and as needed (PRN) every 8 hours for severe agitation. A review of the nurses notes dated 2/16/19, at 10:15 AM, revealed the resident was exhibiting aggressive behavior, trying to hit staff and other residents and yelling. The Medical Doctor (MD) was notified and gave the PRN order for Ativan. A review of the Medication Administration Record (MAR) for February 2019, with the Director of Nursing (DON) present, revealed, there was no	F 758	F758 Free from Unnec Psychotropic Meds/PRN use CFRG): 483.45(c)(3)(e)(1)-(5) Bullet 1. Corrective actions accomplished for alleged deficient practice. A. Facility policy for as needed (PRN) order for antipsychotic and psychotropic medications was present during survey (2/21/2019 - 2/23/2019) that includes limit PRN order to 14 days. B. On 2/22/2019 Resident #27 was assessed by Registered Nurse(RN) and no ill effects was noted. C. On 2/22/2019 Resident #27 order was reviewed by Minimum Data Set Nurse(MDS) and the Physician was notified for clarification. The order reads PRN orders for Haldol 10 milligrams (mg) intramuscularly (IM) NOW, Benadryl 50 mg IM NOW and Ativan 1 mg NOW and as needed PRN every 8 hours for severe	

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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) COMPLETION DATE
F 758	Continued From page 12 stop date written on the MAR for the 2/16/19 order. The MAR revealed, the resident received this dose on 2/16/19, and has not received another dose as of 2/22/19. An interview, on 02/22/19 at 03:00 PM, with the DON, revealed there is an automatic 14 day stop date on all PRN antipsychotics and psychotropic meds, and that the pharmacy will not fill them after 14 days. The DON confirmed, no stop date was written on the 2/16/19 order. An interview, on 2/22/19 at 03:11 PM, with Registered Nurse (RN) #3/Minimum Data Set (MDS) Nurse, confirmed she entered the physician orders into the computer. She stated, a stop date was not entered into the computer for the PRN antipsychotic or psychotropic medications, and that the doctor would have to order a stop date. RN #3 stated, the doctors don't usually put a stop date on those like they do antibiotics. She stated, that she does not recall hearing anything about limiting these medications to 14 days. RN #3 further stated,"We put the order in how its written."	F 758	agitation. The order was clarified on 2/22/2019 and a stop date of 3/02/2019 was entered on the order. Bullet 2. All residents have the potential to be affected by this deficient practice. A. On 3/08/2019 a facility chart review was completed by a Pharmacy Consultant (census of 58) regarding the deficient practice. All deficient practice found was addressed with the Director of Nurses(DON). The DON notified the Psychiatrist with orders addressed and completed. On 4/09/19 a facility chart review was completed by a Pharmacy Consultant (census of 56) regarding the deficient practice. All deficient practice found was addressed with the DON. The DON notified the Psychiatrist with orders addressed and completed. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. DON in-serviced by local Administrator on 4/09/2019 as the importance of 14 days limit on as needed (PRN) orders for antipsychotic and psychotropic medications. B. Medication Nurses, Charge Nurses in-serviced on 4/09/2019 by a local Administrator/Former DON/RN as to the importance of 14 day limit on as needed (PRN) orders for antipsychotic and psychotropic medications.	

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	25E115	A. BUILDING _____ B. WING _____	02/23/2019

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F 758	Continued From page 13	F 758	C. Pharmacy Consultant in-serviced DON and Nursing staff on 4/09/2019 as to the importance of the 14 day stop order on as needed (PRN) orders for antipsychotic and psychotropic medications. D. On 4/09/2019, MDS Nurse was in-serviced by local Administrator/Former Director of Nurses /RN as to the importance of order entry on the Medication Administration Record (MAR) as to the importance of the 14 day limit on as needed (PRN) orders for antipsychotic and psychotropic medications. E. Pharmacy Consultant will continue monthly chart reviews and address orders for PRN psychotropic meds. All deficient practice will be addressed with the DON according to facility policy. Bullet 4. DON will monitor PRN orders for antipsychotic and psychotropic medications for the 14 day limit. The DON will monitor 2 X a week X 3 weeks then weekly X 4 weeks and then monthly. Findings will be reported to Quality Assurance Committee(QA) by the DON on a monthly basis. QA will review and evaluate findings with recommendations on changes as needed. DON is responsible to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/10/19

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F 880	Continued From page 14 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to prevent the potential spread of infection as evidenced by, the nurse placed the resident's inhaler and eye drops in her pocket for one (1) of four (4) medication administration observations; Resident #47. Findings include: Review of the facility's policy titled, "Infection	F 880	F880 Infection Prevention and Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Bullet 1. Corrective actions accomplish for alleged deficient practice: A. On 2/22/2019 Resident #47 was assessed by a Registered Nurse (RN) and no ill effects was noted. B. On 2/22/2019 Resident #47 chart was	

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F 880	Continued From page 16 Control Program Overview", dated 2004, revealed, 1. The goals of the Infection Control Program are to: A. Decrease the risk of infection to residents and personnel....D. Insure compliance with state and federal regulations relating to infection control." On 02/22/19, at 9:26 AM, during an observation of medication pass for Resident #47, Registered Nurse #1 (RN) stated, "This is the hard part, this is where the pockets come in." RN #1 placed a Ventolin inhaler and a box of Timolol eye drops into her pocket and transported them into the resident's room. After administration of the medications, the RN placed the inhaler and eye drop box back into her pocket, and then into the medication cart. An interview with RN# 1, on 2/22/19 at 9:30 AM, revealed, she stated, the pocket is considered "not clean" and that it would cause contamination of the medication cart. On 2/22/19, at 9:49 AM, an interview with the Director of Nursing (DON), revealed, she stated, using pockets to transport medication is definitely an infection control issue.	F 880	reviewed by a RN for potential harm due to Infection Control issues. Director of Nurses(DON) determined that Resident #47 suffered no ill effects at this time due to Infection control issues due to inhaler being place in a coat pocket. C. RN #1 was in-serviced by Administrator on 2/22/2019 regarding infection control and not placing any medicines inside her pockets. Bullet 2. All residents have the potential to be affected by this deficient practice. A. A facility walking audit was completed by a RN assessing for infection control concerns in which findings were corrected on 2/22/2019. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. An in-service was held on 4/08/2019 by the Administrator with the DON about the importance of The Infection Prevention and Control Polices and Procedures. B. An in-service for DON and Nursing Staff was held on 4/09/2019 by a local Administrator, former DON/RN as to the importance of the Infection Prevention and Control Program. C. An in-service was held n 4/09/2019 by the Pharmacy Consultants with DON and Nursing Staff about Infection Prevention	

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F 880	Continued From page 17	F 880	and Control. D. Disposable trays were bought and placed in service, to be used to transport items to the resident room, if needed and are to be disposed of, so that the medication cart is not contaminated. All Nurses Staff was in-serviced 4/09/2019 by local Administrator. Bullet 4. DON is responsible to ensure compliance. DON will monitor Infection Prevention and Control Program weekly X 4 weeks then monthly to ensure compliance. Findings will be reported to Quality Assurance (QA) Committee on a monthly basis. The QA Committee will evaluate findings and make recommendations to improve or prevent infection concerns.	

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	25E115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/21/2019**

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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 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 Chapter 10, and NFPA 101 section 9.6. The deficient practice affected all smoke compartments and all 57 residents in facility on the day of survey. Findings include:	K 341	"Preparation an/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is prepared and/or executed solely because it is required by provision of Federal and State Law."	4/10/19

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

Electronically Signed | 04/10/2019

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 341	Continued From page 1 On 2/21/19 at 10:20 AM, observation revealed a "trouble signal" on the fire alarm system panel in the facility. The Maintenance Supervisor was unable to reset the fire alarm panel to "normal" mode. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 2/21/19.	K 341	K 341 Fire Alarm System - Installation CFR(s): NAPA 101 Bullet 1. Corrective actions accomplished for alleged deficient practice: A. Fire Alarm Panel vendor on 2/25/2019 serviced the Fire Panel and returned to normal mode. B. Fire Alarm Panel vendor on 3/25/2019 serviced The Sprinkler System and noted that Fire Panel was all clear. C. Photographs of Alarm Panel in "normal" mode were taken on 3/13/2019 and 4/5/2019. Bullet 2. All residents have the potential to be affected by this deficient practice. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. Administrator and Maintenance staff were in-serviced by a local Administrator on 4/8/2019 about the importance of maintaining the Fire Panel in "normal" mode. B. Administrator and Maintenance staff will monitor the Fire Panel on a regular work day basis to ensure Panel is in a "normal" mode.	

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K 341	Continued From page 2	K 341	Bullet 4. Administrator will monitor this deficient practice monthly for six months. Administrator will report findings to the QA committee on a quarterly basis. Administrator is responsible to ensure compliance with Fire Alarm regulations.	

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E 004	Continued From page 2	E 004	A. Administrator and Maintenance Staff were in-serviced by a local Administrator on 4/8/2019 about the importance of annually updating and exercising The Emergency Plan. B. The Plan was exercised by the Administrator and After Action Reports were generated and reviewed for improvements. C. Administrator will ensure compliance with regulation regarding Emergency Plan annual updates. Bullet 4. Administrator will monitor this deficient practice monthly for six months. Administrator is responsible to ensure compliance. Administrator will report to QA committee on a quarterly basis.	