STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 survey at the facility from 09/09/19 to 09/12/19 During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid requirements for participation. The SA cited a deficiency at F641.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to accurately complete the Minimum Data Set (MDS) for the correct discharge, and the administration of antipsychotic medications for two (2) of 21 resident Minimum Data Sets reviewed, Residents #79 and #49. Findings include: Review of the facility's policy revealed that the facility follows the Centers for Medicare Services Resident Assessment Instrument (RAI) Version 3.0 Manual, "The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status". Resident #79 Record review of a Physician's Order, dated 08/07/19, revealed Resident #79 was discharged	F 641	A. On 9/11/19, the Minimum Data Set (MDS) Coordinator immediately reviewed the Quarterly MDS assessment, dated 8/9/19, for Resident #79 and revised Section A2100 to reflect that the resident had been discharged home. Resident #49 s Quarterly MDS assessment, dated 8/9/19 was revised to reflect accurate coding of Section N (Medications) to indicate the resident did not receive antipsychotic medications during the seven day look back period. B. All residents have the potential to be affected by this deficient practice allegation of failure of accuracy of assessments. C. The Interdisciplinary Team Members initiated a 100% audit of MDS Assessments with emphasis on the coding of Section A2100 and Section N for the most recent assessment of all	10/18/19

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F 641	Continued From page 1 home with (Name of Home Health) on 08/09/19. Record review of the Social Worker Discharge to Home-Durable Medical Equipment (DME)-Follow up Appointment Instructions, dated 08/09/19, revealed Resident #28 was discharged home with home health. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/19, revealed the Discharge Status in Section A, Item A2100, was coded as discharged to an acute hospital. Record review of the Discharge Summary, dated 08/12/19, revealed the resident was discharged, on 08/09/19, home with family. The reason for discharge was "Condition Improved". On 09/11/19, at 2:32 PM, an interview with the Assistant Director of Nursing (ADON), revealed the MDS was coded wrong, that Resident #79 went home. On 09/11/19 2:35 PM, an interview with MDS Coordinator, revealed the Discharge MDS, with an ARD of 08/09/19, was coded wrong. She stated she checked the wrong box and it should have been coded discharge to home. The MDS Coordinator stated, "We are supposed to check to be sure of the accuracy before we close it" and that the facility follows the Resident Assessment Instrument (RAI) manual policy. She stated she would do a correction for that assessment. Review of the Face Sheet for Resident #79 revealed the resident was admitted by the facility, on 5/29/19, with a primary diagnosis of Infective Endocarditis.	F 641	residents on 9/11/19. No negative findings were noted. An in-service education program was conducted by Director of Nursing with Interdisciplinary team addressing the importance of coding the MDS assessment accurately. The facility s Medicare/Resident Assessment Instrument policy was discussed. The MDS nurse(s) formulated a system practice to monitor accuracy of assessment prior to MDS submission, which includes monthly monitoring of Section A2100 and Section N to be completed by the Interdisciplinary Team. The MDS Team will print Medication Administration Records (MAR) and double check coding before submitting MDS assessments for transmission. D. Director of Nursing will conduct a random audit of five (5) residents MDS assessments for four (4) consecutive weeks. These residents and their MDS assessments will be audited to ensure accurate coding of Section A2100 and Section N. The Quality Assurance Performance Improvement committee will review monthly and make recommendations for negative findings as needed.	

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F 641	Continued From page 2	F 641		

Resident #49

Review of the Quarterly MDS, with an ARD of 8/9/2019, revealed the MDS was coded that the resident received seven (7) days of an antipsychotic medication during the seven day look back period.

Review of the Medication Administration Record (MAR) for August 2019 revealed Resident #49 did not have any antipsychotic medications administered. Review of the Physician's Orders for August 2019 revealed no antipsychotic medications were ordered.

Review of the Care Plan revealed no antipsychotic medications were identified as a concern/problem/need.

An interview with Registered Nurse (RN) #1, on 09/11/2019 at 4:30 PM, revealed the information for how many days a resident receives a medication is taken from the Medication Administration Record (MAR). She could not locate on the MAR where the resident received a dose of an antipsychotic medication. RN #1 stated that it was an error in coding. RN #1 stated, "it's very important that they are coded correctly, due to that drives the Care Area Assessments (CAAs), care plans, and how we take care of the residents."

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	255234	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/10/2019**

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K 000	INITIAL COMMENTS 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=D	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 in accordance to NFPA Chapter 10 and NFPA 101 section 9.6. The deficient practice affected all smoke compartments and all 100 residents in facility on the day of survey. Findings include:	K 341	A. On 9/10/19, the Maintenance Director contacted an AT&T Representative and a Corporate Information Technology Representative about fire panel phone line 2 not working properly. On 9/11/19, an AT&T representative came to the facility and verified the deficient that phone line 2 was not working. On 9/11/19, a Johnson	10/18/19

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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.

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K 341	Continued From page 1 On 9/10/19 at 1:20 PM, 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. Based on phone interview with the fire alarm monitoring company, the trouble signal on the fire alarm panel was for non-working backup phone line. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 9/10/19.	K 341	Control Company representative came to the facility and identified that a CAT5 cable was needed to resolve the issue. On 9/16/19, the facility's Corporate Information Technology department contracted C & S Communications Company to install a CAT5 cable. CAT5 cable was installed and phone line 2 was repaired on 9/16/19. B. All residents had the potential to be affected by this deficient practice. Starting on 9/16/19, Maintenance Director or designee monitored the fire panel for proper functioning daily. C. Maintenance Director conducted an in-service on 9/16/19 to provide education to staff about proper functioning of the fire panel. Areas discussed were facility's plan of correction regarding the deficiency practice, facility's policies and procedures related to the deficiency practice and facility's monitoring tools that will be used to verify compliance. D. Maintenance Director will monitor and complete validation checklist 1 x weekly to assure phone line 2 are functioning and fire panel in in normal mode. . Quality Assurance Performance Improvement committee will review monthly. Quality Assurance Performance Improvement committee will make recommendations for negative findings as needed.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/10/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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