STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. BUILDING _____ B. WING _____	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	627 MIDDLETON ROAD WINONA, MS 38967

(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 An annual recertificaton survey was conducted from 11/18/18 through 11/20/18 by the State Survey Agency. The State Agency determined the facility failed to meet Medicare and Medicaid requirements for participation. Deficiencies were cited at F655, F657, F684, F812, and F880. The census at the time of the survey was 97, and the facility was licensed for 120 beds.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		1/20/19

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

Electronically Signed | 01/17/2019

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

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F 655	Continued From page 1 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, facility policy review, and record review, the facility failed to review and provide the baseline care plan to the resident for one (1) of five (5) new admissions reviewed. (Resident #60) Findings include: Review of the Plans of Care policy, revised 09/25/17, revealed an individualized person-centered plan of care will be established by the interdisciplinary team with the resident and/or the resident representative. The policy noted the facility would develop and implement a base-line care plan within 48 hours of admission. Review of the face sheet for Resident #60 revealed diagnoses including Type II Diabetes, Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. The resident was	F 655	1.Root Cause Analysis (RCA) was completed on 12/20/18 by Quality Assurance Performance Improvement (QAPI) committee and based on findings, a Care Conference to discuss individualized care with Resident #60 and Responsible Party (RP) was scheduled by Social Services Director (SSD) on 12/20/18. Resident #60 and her Responsible Party (RP) were provided with a copy of the baseline and other care plans on 12/26/18 by Social Services Director (SSD). 2. All newly admitted/ readmitted residents have the potential to be affected by this	

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F 655	Continued From page 2 admitted on 05/21/18. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/18, revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 of 15. Review of the baseline care plan, dated 05/21/18, revealed no signature from the resident and/or the resident representative under the section, "Below are signatures and dates signifying the final review of the baseline care plan with transition to the comprehensive care plan." Only one signature by the nurse was documented under the section, "Below are the completion signatures and dates of those participating in the initial baseline care plan development and summary." Resident #60 was interviewed on 12/18/18 at 11:00 AM. When asked if staff involved her in her care, she said "No, they don't." The Director of Nursing (DON) was interviewed on 12/20/18 at 8:27 AM. She confirmed the baseline care plan was not documented as reviewed and received by the resident and/or resident representative. She had talked to the nurse who filled out the baseline care plan and told her they needed the involvement of the resident and representative.	F 655	deficient practice. A Baseline Care plan Quality Review of residents who were admitted in the last 30 days was conducted by the Director of Nurses (DON) on 1/14/19 to ensure a baseline care plan was completed and that each Resident and/or Responsible Party had received a copy. Any negative findings were corrected by the Director of Nurses (DON)and Interdisciplinary Team (IDT) upon identification. 3.Reeducation with facility nurses regarding the completion of baseline care plans per facility policy was initiated by the Director of Nurses (DON) on 12/20/18 to ensure baseline care plans are developed timely and that Residents and/or Responsible Parties are provided a copy. 4.Quality reviews of newly admitted residents to ensure that a baseline care plan has been developed and that a copy has been provided to Resident and/or Responsible Party will be conducted by Social Services Director or Director of Nurses (DON)Five (5)x per week x Four (4) weeks, then weekly x Four (4) weeks, then monthly x Four (4) months until substantial compliance is achieved.	

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F 655	Continued From page 3	F 655	Substantial compliance will be based on results of quality reviews. Quality reviews will be taken to Quality Assurance Performance Improvement (QAPI) committee monthly by Social Services Director (SSD)or Director of Nurses (DON) x Six (6) months for further review and/or recommendations. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Plan (PIP) as indicated by findings. 5.AOC: 1/20/19	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		1/20/19

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F 657	Continued From page 4 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review, the facility failed to include the resident in the care planning process for one (1) of 21 care plans reviewed. (Resident #60) Findings include: Review of the facility's "Care Plans" policy, revised 9/25/17, revealed: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Review of the Care Plan and "Care Conference Record" revealed the following: -06/07/18: Admission: There were five signatures of staff with no documentation of the resident and/or representative in attendance. No comments marked. -08/28/18: Quarterly: There were four signatures of staff with no documentation of the resident and/or representative in attendance. No comments marked. -11/15/18: Quarterly: There were four signatures	F 657	1. Root Cause Analysis (RCA) was completed on 12/20/18 by Quality Assurance Performance Improvement (QAPI) committee and based on findings, a Care conference to discuss individualized care with Resident #60 and Responsible Party was scheduled by Social Services Director (SSD) on 12/20/18. Resident #60 and her Responsible Party were provided with a copy of the baseline and other care plans on 12/26/18 by Social Services Director(SSD). 2. All residents have the potential to be affected by this deficient practice. A Quality Review to ensure that Residents and/or their Responsible Parties had participated in care plan revision conferences timely was conducted by the Social Services Director on 12/20/18. Any negative findings were corrected immediately upon identification by the Social Services Director (SSD). 3. Reeducation with Social Services Director (SSD) and Minimal Data Set (MDS) nurses regarding the completion of	

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F 657	Continued From page 5 of staff with no documentation of the resident and/or representative in attendance. No comments marked. Review of the face sheet for Resident #60 revealed diagnoses including Type II Diabetes, Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. The resident was admitted on 05/21/18. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/18, revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 of 15. Resident #60 was interviewed on 12/18/18 at 11:00 AM. When asked if staff involved her in her care, she said "No, they don't." On 12/20/18 at 8:22 AM, she stated there were no care conferences. She had never gone and had never been invited. Social Worker #1 was interviewed on 12/20/18 at 7:48 AM. She stated they sent out letters for the care conferences and that was how they kept track of who was invited to attend. They only had letters for August and November for this resident. They did not always document what was discussed at the meetings. Something was documented in the comment section when there was a concern. They were doing more phone conferences since it was so hard getting people to attend. The Director of Nursing was interviewed on 12/20/18 at 8:14 AM. She confirmed that they documented only when there was a concern. If the resident and/or representative was not marked, then they did not attend.	F 657	care plans revision conferences per facility policy was initiated by the Director of Nurses (DON) on 1/14/19. 4.Quality reviews of Five (5) Residents' records to ensure that a care plan revision conference has been scheduled will be conducted by Social Services Director (SSD) or Director of Nurses (DON) weekly x Four (4) weeks, then monthly x Five (5) months until substantial compliance is achieved. Substantial compliance will be based on results of quality reviews. Quality reviews will be taken to Quality Assurance Performance Improvement (QAPI) committee by Social Services Director (SSD) or Director of Nurses (DON) monthly x Six (6) months for further review and/or recommendations. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Plan (PIP) as indicated by findings. 5. AOC: 1/20/19	

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to perform glucose monitoring for two (2) of two (2) residents and administration of insulin doses as prescribed by the physician for one (1) of two (2) residents reviewed for insulin administration. Resident #3 and #60. Findings include: Review of the Blood Glucose Monitoring and Disinfecting policy, revised 09/28/17, revealed verify physician order ...document result in medical record. Resident #3 Record review of Resident #3's Physicians's orders revealed an order for accucheck before meals and at bed time. Record review of Resident #3's, blood glucose level monitoring form, revealed the ordered accucheck was not performed on 10/3/18 and 10/12/18. On 12/20/18 at 11:21 AM an interview with the Director of Nursing confirmed that Resident #3 had an order for fingersticks before meals and at	F 684	1. Root Cause Analysis (RCA) was completed on 12/20/18 by Quality Assurance Performance Improvement (QAPI) committee and based on findings Resident #60 and Resident #3 were assessed by Director of Nurses (DON) on 12/20/18 to ensure blood sugar monitoring was conducted as ordered by the Physician and that residents had received the correct dosage. Physician/ Nurse Practitioner was notified by Director of Nurses (DON) of negative findings on 12/20/18. 2. Other residents with Physician orders to monitor blood glucose and/or who receive insulin have the potential to be affected by the alleged deficient practice. These residents were assessed by DON Designee on 12/20/18. There were no negative findings upon assessment of these residents. 3. Reeducation with Facility Nurses regarding following Provider orders for blood glucose monitoring and insulin dosage administration was initiated by the Director of Nurses (DON) on	1/20/19

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F 684	Continued From page 7 bed time and on 10/3/18 and 10/12/18 the blood glucose monitoring form did not have documentation that the accucheck was performed on 10/3/18 and 10/12/18. The DON confirmed Resident #3 was not on a leave of absence from the facility or did not refuse the fingerstick on 10/3/18 and 10/12/18. On 12/20/18 at 11:30 AM an interview with Resident #3 revealed she does get her finger stuck for blood sugar levels but could not remember how often or if any had ever been missed. Resident #60 Review of the face sheet for Resident #60 revealed a diagnosis of Type II Diabetes. The resident was admitted on 05/21/18. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/18, revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 of 15. Review of the December Physician's Orders revealed: On 05/29/18: Accucheck AC (before meals) and HS (bedtime) with Humulin R ...Sliding scale blood sugars: 70-200= 0 units; 201-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units; greater than 400= 12 units and call medical doctor (MD). Review of the December 2018 Resident Diabetic Orders form revealed: On 12/02/18 at 4:00 PM: Blood sugar results was 369, with six (6) units of insulin given and should have been eight (8) units, per physician's orders.	F 684	12/27/18. 4. Quality reviews of Five (5) residents' Medication Administration Records to ensure that blood glucose has been monitored per provider order and that proper insulin dosage was administered will be conducted by Director of Nurses or Registered Nurse Supervisor Five (5)x per week x Four (4) weeks, then weekly x Four (4) weeks, then monthly x Four(4) months until substantial compliance is achieved. Substantial compliance will be based on results of quality reviews. Quality reviews will be taken to Quality Assurance Performance Improvement (QAPI) committee by Director of Nurses (DON) or Registered Nurse Supervisor monthly x Six (6) months for further review and/or recommendations. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Plan (PIP) as indicated by findings. 5. AOC: 1/20/19	

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F 684	Continued From page 8 Review of the November 2018 Resident Diabetic Orders form revealed the following dates/times of no documented Blood sugar:: -11/10/18 at 4:00 PM: blank -11/16/18 at 8:00 PM: blank -11/25/18 at 11:00 AM: blank -11/25/18 at 4:00 PM: blank Review of the October 2018 Resident Diabetic Orders form revealed: -10/04/18 at 11:00 AM: blank -10/20/18 at 11:00 AM: Blood sugar results of 259, with two (2) units given, and should have been four (4) units of insulin. -10/24/18 at 11:00 AM: blank -10/25/18 at 11:00 AM: blank The Director of Nursing was interviewed on 12/20/18 at 9:13 AM. She confirmed the incorrect insulin dosages documented for the two (2) times. She also confirmed the missing blood sugar monitoring. She stated if it had been refused, that time section would have been initialed and circled. She confirmed these missed times were not refused. At 9:43 AM, she confirmed the insulin dosages needed to be correct and the staff should have been following the physician orders for the accuchecks four times a day. Review of the metabolic care plan for Resident #60, dated 11/20/18, revealed at risk for metabolic complications. Interventions included: blood glucose levels as ordered.	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/20/19

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F 812	Continued From page 9 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and the Food Code standard review, the facility failed to serve food in accordance with professional standards for food service safety. Specifically, the facility failed to serve food in a sanitary manner by touching ready-to-eat foods with bare hands for one (1) of one (1) dining room observations. Findings include: Review of the 2017 Food Code by the U.S. Food and Drug Administration, page 69, revealed employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils. The dining room was observed on 12/18/18 at 11:48 AM. An unidentified staff member was observed serving food to a resident. She picked	F 812	1. Root Cause Analysis (RCA) was completed on 12/20/18 by Quality Assurance Performance Improvement (QAPI) committee and based on findings a dining room meal service was observed by Director of Nurses (DON) on 12/20/18 to ensure that staff were serving food in a sanitary manner. 2. Residents residing in the center have the potential to be affected by the alleged deficient practice. 3.Reeducation regarding safe and sanitary handling of food was initiated by Director of Nurses (DON) and Staff Development Nurse on 12/20/18 with facility staff. 4. Quality observation of meal service to	

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F 812	Continued From page 10 up a roll with her bare left hand. She tore the bread apart with her bare left hand and proceeded to put butter on it. At 12:01 PM, she was observed picking up another resident's cornbread with her bare fingers and then placed it back down on a different part of the plate. The dining room was observed again on 12/20/18 at 7:30 AM. Certified Nurse Aide (CNA) #2 was observed opening a resident's biscuit with her bare left hand. She picked up the biscuit with her bare left hand while placing jelly on it and placing the biscuit back down. The resident was observed eating the biscuit. The resident was visually impaired. CNA #3 was observed with long fake nails. She was observed opening a resident's biscuit with her bare left hand while placing jelly on the biscuit. Registered Nurse (RN) #1 was interviewed on 12/20/18 at 8:03 AM. She said she oversaw educating the new employees on feeding techniques, nutrition and hydration. She completed monthly education for all staff. She did not complete any training for the CNA's regarding food service in the dining room. She stated that CNA #3 oversaw that training. CNA #3 was interviewed on 12/20/18 at 9:32 AM. She confirmed she was the one who had overseen training the CNA's in the dining room. When asked about touching ready-to-eat food with bare hands, she was not aware they should not touch food with their bare hands. She stated she could not correct what she did not know was poor practice. She had never been trained on that specifically. The Certified Dietary Manager was interviewed	F 812	ensure safe and sanitary food handling will be conducted by Dietary Manager or Staff Development Nurse Five (5)times per week x Four (4) weeks, then weekly x Four (4) weeks, then monthly x Four (4) months until substantial compliance is achieved. Substantial compliance will be based on results of quality observations. Quality observation results will be taken to Quality Assurance Performance Improvement (QAPI) committee by Dietary Manager of Staff Development Nurse monthly x Six (6) months for further review and/or recommendations. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Plan (PIP) as indicated by findings. 5. AOC: 1/20/19	

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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 812	Continued From page 11 on 12/20/18 at 9:36 AM. She stated that the staff who oversaw hiring also oversaw training the CNA's in the dining room. She thought RN #1 oversaw "all of that." The Director of Nursing was interviewed on 12/20/18 at 10:44 AM. She stated that the staff should have had previous experience before they were hired. CNA #3 was training the staff until she moved into another position. She said she was not aware staff was touching ready-to-eat food with their bare hands.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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;	F 880		1/20/19

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	255171	A. BUILDING _____ B. WING _____	12/20/2018

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F 880	Continued From page 12 §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: (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.	F 880		

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F 880	Continued From page 13 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 possible spread of infection by not following transmission-based precautions for one (1) of seven (7) residents on transmission-based precautions. Two (2) staff were observed in the resident's room without gloves and gown as required for contact isolation. (Resident #24) Findings include: Review of the Isolation-Categories of Transmission-Based Precautions policy received from the Director of Nursing on 12/20/18 at 10:31 AM, revised 01/12, revealed wear gloves when entering the room ...after removing gloves, do not touch potentially contaminated environmental surfaces or items in the resident's room ...wear a disposable gown upon entering the contact precautions room or cubicle. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces. Resident #24 was observed on contact isolation. There was an isolation sign and a cart available containing personal protective equipment outside of the resident's room. Certified Nurse Aide (CNA) #1 was observed on 12/18/18 at 4:13 PM. She was in the resident's room. She appeared to be touching the resident. She was observed moving the bedside table in the room and lowering the residents bed using the handle at the end of the bed. She was observed without a gown or gloves. When interviewed, she said she was checking to make sure the resident had her call	F 880	1. Root Cause Analysis (RCA) was completed on 12/20/18 by Quality Assurance Performance Improvement (QAPI)committee and based on findings, Resident #24 was assessed by Director of Nurses (DON) on 12/20/18. No negative outcomes were noted. 2. Forty nine (49) Residents residing on East wing had the potential to be affected by the alleged deficient practice. Residents were assessed by Director of Nurses (DON) and Registered Nurse Supervisor on 12/20/18 with no negative outcomes noted on assessment. 3. Reeducation with facility staff, including Certified Nursing Assistants and Nurses was conducted on 12/27/18 by Director of Nurses and Staff Development Nurse regarding proper usage of Personal Protective Equipment (PPE) and guidelines of transmission based precautions. 4. Quality observations of Five (5) residents who have provider orders for transmission based precautions will be conducted by Director of Nurses (DON) or Registered Nurse Supervisor weekly x Four (4) weeks, then monthly x Five (5) months until substantial compliance is achieved. Substantial compliance will be based on results of quality reviews. Quality reviews	

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F 880	Continued From page 14 light within reach. When asked about the isolation, she said "Yes, needed gown, gloves and a mask." She said they gowned up while providing care only. When asked if it was acceptable to touch everything else in the room without gowning up or wearing gloves, after a few seconds, she said, "No." Housekeeper #1 was observed on 12/20/18 at 10:02 AM. She went into the resident's room with a trash can and laid the trash can down on the floor, inside the room. She was not wearing gloves or a gown. She put gloves on and carried a spray bottle into the room. She went into the bathroom. She came out of the room and took the gloves off. She took the mop into the room without gloves or a gown. On her way out of the room, she grabbed the handle at the end of the bed and pushed it down. When interviewed, she stated she usually cleaned off the bedside table, dusted, cleaned the bathroom and the commode. When asked if she was aware the resident was on isolation, she said "No." She was only aware of needing to put on gloves and a mask, if needed. She was not aware of needing a gown. When asked about the different types of isolation, she said she did not know. When asked if she knew what contact isolation meant, she said "No." The Director of Nursing was interviewed on 12/20/18 at 10:44 AM. She stated the staff needed to wear a gown and gloves for contact isolation. She expected all staff going into the room wear a gown and gloves. She confirmed the CNA did not use proper practice because she contacted surfaces in the room. She stated that housekeeping needed to wear a gown and gloves for cleaning. She stated she would address that.	F 880	will be taken to Quality Assurance Performance Improvement (QAPI) committee by Director of Nurses (DON)or Registered Nurse Supervisor monthly x Six (6) months for further review and/or recommendations. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Plan (PIP) as indicated by findings. 5. AOC: 1/20/19	

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	255171	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/20/2018**

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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 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		1/20/19

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

Electronically Signed | 01/17/2019

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 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT 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 standard deficiency has the potential to affect entire facility on the day of survey. Findings include: On December 20, 2018 at 11:10 AM, observation and testing revealed the generator was incapable of transferring power to the facility within the required 10 seconds. The generator transferred power to the facility in 17 seconds. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on December 20, 2018.	K 918	K918 NFPA 101-Essential Electrical System 1. Based on finding of Fire Safety tour, 12/20/18, it was revealed that the generator was incapable of transferring the power in the required 10 seconds. The generator transferred power in 17 seconds. 2. A Quality Review of Generator was Conducted by the Maintenance Staff. 3. The maintenance staff has been re-educated on the importance of NFPA 101 Generator. An outside vendor has re-set generator to transfer power within the required time of 10 seconds or less. Maintenance staff will test generator weekly for one month and monthly following initial month to assure proper operation of transfer. 4. Any negative findings will be reported to the QAPI committee and monitored for compliance. Date of completion: January 20, 2019	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 12/20/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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