Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0403	A. BUILDING: ______ B. WING ______	C 12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	**7615 DALLAS CHERRYVILLE HIGHWAY** **CHERRYVILLE, NC 28021**

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type A2 violation Based on observations, policy review, record review and staff interviews, the facility failed to assess and care plan smoking supervision needed, communicate changes in the supervision needed, and supervise 1 of 1 sampled resident who required supervision when smoking. In addition, the facility failed to implement their policy related to keeping smoking materials secured and posting signs designating the smoking area. Resident #3 was found with smoking materials and smoking in his bed during which he burned a hole in his mattress. The findings included: The "Rest Home Smoking Policy" dated 08/12/04 included: Other than the designated areas outside of this facility, there is NO SMOKING anywhere in the building including resident rooms, dining rooms, kitchens. The section of the policy specific to Rest Home Residents (further referred to as Adult Care Home Residents) included:	D 270	Filing the plan of correction does not constitute admission that the deficiency alleged did in fact exist. The allegation of compliance is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. " For Resident #3, the resident voluntarily transferred from the facility to another Assisted Living facility on October 23, 2014. There were no other residents who smoke in the Assisted Living. " The Smoking Policy was revised on December 9, 2014 with changes including assessment for safe smoking on admission, quarterly, and with a change in condition, all smoking paraphernalia will be secured at the nurses station, the facility reserves the right to search a resident□s belongings for smoking materials, and any residents not abiding by the smoking policy and deemed to be putting themselves or others in danger will be given a 30-day discharge notice. " The Resident Handbook was updated to reflect the smoking policy changes.	12/23/14

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D 270	Continued From page 1 1. Residents who are found not to need assistance to smoke may smoke at their discretion care plan in the resident's record. 3. Smoking materials will be kept at thein the appropriate area. 2. A care plan for all smoking residents will be developed and incorporated into the individualized comprehensive Nurses Station unless the resident has been deemed as a smoker who does not need assistance. However, the resident must leave smoking materials in a locked box in their room when not in use. The section referring to Resident Smoking Status stated a resident will be identified as a smoker who does not need assistance to smoke when all of the following criteria are met: 1. A resident must demonstrate manual dexterity (physically capable of handling smoking materials). 2. A resident must demonstrate intact judgement and cognition. 3. A residents must demonstrate the ability to be responsible and refrain from providing other residents with smoking materials. A resident found providing other residents with smoking materials will have their smoking privileges revoked and will be given a 30 day notice of discharge. Interview with the Administrator on 12/09/14 at 11:30 AM revealed that the smoking policy dated 08/12/04 was the policy for the Adult Care Home residents. She further stated that all adult care home residents and responsible parties should have received the 08/12/04 policy on admission. Resident #3 was admitted to the facility on	D 270	The Smoking Policy will be reviewed with the resident and responsible party upon admission by the Assisted Living Coordinator or Admissions Director. " Any new admissions will have the Smoking Risk Assessment completed within 24 hours of admission by the admitting nurse. Completion of the assessment will be monitored by the Director of Nursing. The assessing nurse will immediately document if the resident is a safe or supervised smoker on the Standards of Care communication form. This form is kept at the nurses stations and identifies the individual needs of each resident. During weekly interdisciplinary meetings, each resident□s smoking status is reviewed and any changes are updated by the Administrator. The Smoking Risk Assessment will be completed quarterly thereafter and with any change in the resident□s condition by the charge nurse and any changes documented in the Standards of Care. " Individualized smoking care plans will be developed by the admitting nurse within 24 hours of admission to be reviewed by the MDS Coordinator or Director of Nursing. " Newly admitted residents who smoke will be monitored by the charge nurse via the Smoking Compliance Monitoring Tool for 72 hours and weekly thereafter for 2 weeks. The monitoring includes that the resident can verbalize the highlights of the smoking policy, has returned their smoking materials to the nurses station,	

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09/25/14. His diagnoses included bipolar disorder, muscle weakness, history of alcohol abuse, anxiety, and dementia without behavior disturbances.

Resident #3's Nursing Admission Data Form dated 09/25/14 revealed he had adequate hearing and speech, was legally blind in his left eye, and he had no short or long term memory impairments. He was noted with no behaviors or psychosis, received antianxiety and hypnotic medications, and was independent with transfers, ambulation, used a walker, had steady balance, and he had no range of motion impairments. This form also included a smoking assessment which indicated the following: he smoked cigarettes less than hourly, under smoking in unauthorized areas he was coded as a minimal problem; under being careless with smoking materials he was coded as a minimal problem; under general awareness and orientation including ability to understand the facility smoking policy there was no assessment coded; under general behavior and interpersonal interaction there was no assessment coded; under mobility he was coded as a minimal problem; under capability to follow facility smoking policy he was coded a minimal problem. The only description related to these negative responses stated "needs supervised smoke breaks." The smoking score was a "4". The scoring guide revealed a score from 0-9 indicated a safe smoker and the facility's policy should be followed.

Interview on 12/08/14 at 4:00 PM with Nurse #1, who completed the smoking assessment, revealed that although the computer score for smoking was a 4 indicating Resident #3 was a

has smoked only in designated areas, and has not given any smoking paraphernalia to other residents.

" All residents smoking materials will be kept secure at the nurses station. Residents who are assessed to be a safe smoker will sign their smoking materials in and out via the Smoking Material Sign Out/ In form maintained at the nurses station. Any nursing staff can sign smoking materials in and out for residents.

" Education was provided to the Assisted Living Coordinator on December 10, 2014 by the Administrator regarding the smoking policy revisions, reviewing the smoking policy upon admission, the Standards of Care, the Smoking Risk Assessment, notifying the Administrator of any resident□s non-compliance with the smoking policy, the facility may search the resident□s belongings for smoking materials, and any non-compliance will result in a 30-day discharge notice.

" Education was provided to all staff including contract staff by the Staff Development Coordinator regarding the revised smoking policy, completion of the Smoking Risk Assessment, completion of individualized care plans, designated smoking areas, smoking materials are kept secure at the nurses station, Standards of Care, and the Smoking Compliance Monitoring Tool. This in-service began on December 9, 2014 and will be provided to all staff prior to the start of their shift until 100% of staff are trained. No staff will be allowed to work

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D 270	Continued From page 3 safe smoker, she noted he needed supervised smoke breaks because he was a new admission. She stated she observed him smoking, did not see any indication that he was unsafe, but felt further observation was appropriate. She further stated that she did not complete the cognitive questions but could not say why, only that the computer system did not require those questions be answered. Nurse #1 stated she was not responsible for developing any care plans, that the nurse supervisor was responsible for developing the immediate care plan and the Minimum Data Set (MDS) nurses were responsible for the permanent care plan. During interview with the Administrator on 12/08/14 at 5:26 PM, she stated her expectation was that the smoking assessment be completely filled out. Review of Resident#3's medical record revealed there was no plan of care related to smoking. Interview with the Nurse Supervisor (Nurse #2) on 12/08/14 at 4:46 PM revealed the admission nurse completed the assessment and she signed off on the immediate plan of care. She stated she should have developed an immediate plan of care for his smoking based on the nurses notation for the need for supervised smoke breaks. No explanation was provided for why there was no immediate care plan. Interview on 12/09/14 at 9:30 AM with Nurse #3, one of two facility MDS nurses, revealed there was a "Standards of Care" form kept at the nursing station which included individual resident information, including a list of residents who smoked and what supervision was needed. This	D 270	prior to receiving in-service training. " An audit tool was developed to include the following: o Was the Smoking Risk Assessment completed upon admission and were the results communicated via Standards of Care? o Has there been a change in condition? If so, was the Smoking Risk Assessment completed and results communicated via Standards of Care? o Was an appropriate care plan initiated and updated with any changes? o If the resident requires supervision, is proper supervision being provided at designated times? 100% of all new admissions and all current residents that smoke will be audited for compliance. Audits will be completed by the Director of Nursing or RN Supervisor weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. All audit information will be analyzed and reviewed by the Director of Nursing at the QAPI Committee Meetings.	

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form was accessible for each staff person's knowledge and reviewed and revised each week based on information shared during an interdisciplinary meeting. She stated that if a staff person recognized a need to change a resident's smoking supervision status, staff would bring it to the interdisciplinary meeting for discussion and changes would be made on the Standards of Care form. On 12/09/14 at 12:05 PM, during an interview with both of the MDS nurses (Nurses #3 and #4) stated they had never developed a specific care plan for any adult care home resident who smoked.

Review of the "Standards (of Care) Meeting" notes revealed it consisted of a listing of individual care needs for each resident which was kept at the nursing station. There were no notes relative to any discussions related to the decision or changes made during the interdisciplinary meetings each week. The meeting dated 09/26/14 included that Resident #3 was the only resident who smoked in the adult care home and he needed to be supervised. The Standards Meeting dated 10/03/14 included Resident #3 was changed to being unsupervised during smoking.

A progress note dated 10/09/14 at 9:48 AM, written by the Assisted Living Director, revealed Resident #3 was threatening to leave the facility to get a drink and was very hostile and accusatory with staff and family.

A progress note dated 10/09/14 at 1:22 PM written by the psychiatrist revealed Resident #3's responsible party was concerned about the resident's escalating behaviors and the responsible party revealed a significant history of impulsive/difficult to manage behaviors for many

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D 270	Continued From page 5 years. The physician noted changes in the resident's medications at this time. The Standards Meeting notes dated 10/10/14 included Resident #3 was still listed as needing no supervision during smoking. A progress note dated 10/10/14 at 10:57 PM written by Nurse #5, revealed she noted the "resident to be 'lost' on the skilled side of the building on 2 different occasions this shift." The note continued that staff brought out from him room an empty 16 ounce mouthwash bottle, an empty 8 ounce after shave bottle and 4 other bottles of after shave, cologne and pre shave cream 2 of which were empty and 2 were half empty. The nurse assessed Resident #3 and noted his speech to be slurred compared to usual. An order was obtained for an alcohol level. The results of the specimen dated 10/10/14 revealed Ethanol was 5 milligrams mg/DL indicating a high level with normal being less than 5 mg/DL. A nursing note dated 10/11/14 at 2:50 PM revealed Resident #3 went out to smoke as desired. The Administrator stated on 12/09/14 at 1:29 PM she was unable to locate the Standards Meeting notes for 10/17/14 to show any changes made relating to smoking supervision for Resident #3. A nursing note dated 10/20/14 at 2:11 PM revealed Resident #3 ambulated across to other end of building without his walker, was looking for his walker, and the walker was found in his room. Although Resident #3 stated he was walking with the Assisted Living Director, the resident was not observed with the Assisted Living Director.	D 270		

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A nursing note written by Nurse #2, dated 10/21/14 at 11:30 PM and noted as a late entry, revealed she was notified by medication aides that they smelled cigarette smoke coming from the resident's room. When staff entered the room the odor of cigarette smoke was evident and burned holes were found in Resident #3's mattress. Nurse and medication techs searched the resident's room and found a half empty pack of cigarettes and 2 lighters. A further search revealed no other materials. The nurse explained to the resident that smoking in the building was not allowed and the dangers of him smoking in the building. The note continued that the resident was noncompliant with staff's instructions and redirection and cursed at staff. The note also specified that the Assisted Living Director was notified of the resident's inappropriate behavior.

Medication Tech (MT) #2 who worked first shift was interviewed on 12/08/14 at 2:51 PM. MT #2 stated cigarettes had been removed from Resident #3 several times. MT #2 stated one morning, date unknown, she entered his room and saw a cigarette on the floor that looked as if a cigarette was put out on the floor by stepping on it. She stated she smelled smoke. He was noted to have several cigarettes in bed with him. She stated she removed the cigarettes and asked him if he was smoking which he denied. Resident #3 cursed at her when she told him he needed to smoke in the proper location. She stated after that she refused to keep cigarettes for him and gave them to the Assisted Living Director to give to the Resident because the resident wanted them every 10 minutes. Upon further questioning, she stated she thought the day she smelled smoke and found the cigarette smashed on the bedroom floor was the day before or the day after

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he burnt a hole in his mattress. She stated it was a new mattress that no one had ever slept on before. A follow up interview was held with MT #2 on 12/09/14 at 12:10 PM. MT #2 stated prior to the burned mattress incident, she had found cigarettes on Resident #3 twice before. She stated she had second shift remove the cigarettes from him. She stated when she asked for a lighter he denied having one and he told her to search him. She did not because she did not think it was the right thing to do. She stated she informed the Assisted Living Director and reeducated the resident about the smoking rules. She further stated that she thought the day she found the cigarette put on the floor was the day after the mattress burned.

An interview was conducted on 12/08/14 at 2:59 PM with MT #1 who worked on the second shift. She stated she removed cigarettes from Resident #3's possession several times. MT #1 stated that before the incident on 10/21/14, staff gave him 2 cigarettes at a time to smoke but no lighter because staff knew he carried his own lighter. She stated that upon return, staff tried to make sure he gave them any cigarettes he had not smoked because they knew he had a lighter which he would never give to staff. Regarding the incident of 10/21/14, she stated that she and another nurse aide (identified as NA #1) were leaving for the night after working 2nd shift and smelled smoke. When they entered Resident #3's room, she stated the smell of smoke was greater describing it as a "big time" smoke smell. She stated she suspected he was pretending to sleep and in looking for the source of smoke, saw a burn hole in the sheet and the mattress of the resident's bed. She stated staff looked in the drawers and found a black plastic sugar packet holder that had several extinguished cigarettes

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and ashes inside which she said looked like it was used as an ashtray. Additionally they confiscated more cigarettes and 3 to 4 lighters from the resident's room. She stated she told Nurse #6 of the smoke smell and burned mattress. She stated there were no changes to Resident #3's care as he did not get out of bed to smoke before he was discharged.

An interview with Nurse #2 was held on 12/08/14 at 4:46 PM. Nurse #2 stated she thought Resident #3 needed to be supervised when smoking. She stated she found him multiple times when she suspected he was smoking in the building. Once she smelled smoke, found him in the bathroom and he hurriedly flushed the commode. She told him at this time he could not keep cigarettes on him. She recalled another time on the back hallway, Resident #3 smelled of a heavy smoke odor and he acted like he pushed something in his pocket. She asked him if he was smoking and if he had cigarettes and he denied both. She stated "I knew it was in his jacket but was not going to press him." She further recalled confiscating cigarettes from him during his stay at the facility. Follow up phone interview on 12/09/14 at 12:37 PM with Nurse #2 revealed she was not sure the exact dates of the events of suspecting him smoking in the building, but in review of the schedules and calendars she confirmed she did not work after the mattress was found burned so it was before 10/21/14. She stated she did not press him for the cigarettes when she suspected he was smoking in the building because "hindsight was 20/20." She stated she told the Assisted Living Director of these incidents and also educated Resident #3 of the rules and not being allowed to smoke in the building. She further stated she should have updated his care plan to ensure he was listed as

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needing to be supervised during smoking which she based on the episodes of his erratic behaviors and suspected drinking of mouthwash and other alcohol based products.

On 12/09/14 at 10:00 AM the mattress with the burn hole was observed with the maintenance staff. The hole was the size of the end of a cigarette and burned through the attached outer mattress covering. The hole was approximately 18 inches from the side of the mattress and from the end of the mattress.

A telephone interview with NA #1 was conducted on 12/09/14 at 10:23 AM. NA #1 stated that Resident #3 kept short partially smoked cigarettes in his pockets and had 4 lighters in his room one of which he carried in his pocket. She further stated that she reported the cigarettes and lighters to the Assisted Living Director who she observed trying to remove the smoking materials from Resident #3 who refused to give them up saying they were his personal property and he paid for them. She could not recall the time frame of this incident. She then stated there was another incident where during change of shift, she was leaving and she smelled smoke coming from Resident #3's room. NA #1 stated she reported her observations to Nurse #6. NA #1 stated Resident #3's cigarettes were observed loose in the bedside drawer.

A telephone interview with Nurse #6 on 12/09/14 at 11:37 AM relating to the incident of 10/21/14. Nurse #6 stated he could not recall the date but approximately 2 months ago at approximately 10:45 PM, he was asked to go to the rest home section (the hall for Resident #3) to retrieve smoking materials from a resident. He stated that it took him awhile to get to the 400 hall and that

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once he got there, staff had already removed the lighters and cigarettes from the resident's room.

Nurse #5 was interviewed on 12/09/14 at 3:43 PM. She revealed she was the evening shift supervisor. She stated that each rest home resident had a nurse located on the skilled unit assigned to them. As the supervisor, Nurse #5 often would handle issues for the nurses when needed on the rest home. She recalled that the first night Resident #3 was in the facility he was supervised as they were waiting for the evaluation to be completed. After the initial evaluation, Resident #3 was deemed safe to smoke unassisted and he would tell staff when he was going out to smoke. Nurse #5 stated that after the first couple of weeks, Resident #3 was suspected of drinking mouthwash for the alcohol content and started with erratic behaviors and subsequently deemed unsafe to smoke independently. Nurse #5 stated after he was supposed to be supervised during smoking and before the burned mattress incident, she saw him outside, pull out pieces of cigarettes of different varieties, and then pull out a lighter and light a partial cigarette. She stated she stood with him while he smoked and observed him drop a lit cigarette into his lap. She stated he was stumbling and had slurred speech. She tried to educate him on the need for him to be supervised during smoking. After he was done smoking he walked back inside the building but refused to give his lighter to Nurse #5. She stated the normal procedure was to leave notes for the Assisted Living Director or voice mails for him about any concerns she encountered. She stated she may have written a note for the Assisted Living Director but then stated Resident #3 had daily behaviors to report and that she thought she told the Assisted Living Director.

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D 270	Continued From page 11 Interview with the Assisted Living Director on 12/08/14 at 2:31 PM revealed he had observed Resident #3 smoking in the nondesignated courtyard, found cigarette butts in his room, and or found a partially smoked cigarette on his person at least 6 to 8 times prior to the burned mattress incident. He stated he learned about the burned mattress the day following the incident. He was not sure if the incident had been investigated or if any changes were made to address the issue of him smoking in bed. Follow up interview on 12/08/14 at 5:26 PM revealed that when the Assisted Living Director would find him smoking in the nonsmoking courtyard, he redirected the resident. The Assisted Living Director stated he did not look at the Standards of Care and did not know if he was supposed to be supervised or not during smoking, just that he was smoking in the wrong area. He stated he did not report these incidents to the Administrator but instructed staff to keep an eye on him. The Assisted Living Director stated he was unaware of Nurse #2's observations of Resident #3 smoking in the building. On 12/09/14 at 11:30 AM the Assisted Living Director stated he gave a copy of the Resident Handbook to the resident and the responsible party, instructed them to read it and ask him if they had any questions. A signed acknowledgment of receipt of the handbook dated 09/25/14 and signed by the responsible party was observed in the business office's records. On 12/09/14 at 12:55 PM he stated he did not review the smoking policy with either the resident or his responsible party and did not give either a copy of the smoking policy dated 08/12/14 specific to the adult care home residents as he did not know it existed. He further stated he never had Resident #3 sign a receipt indicating he received the Resident	D 270		

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Handbook. He stated each time he found Resident #3 smoking in the nonsmoking courtyard, he removed the smoking materials and escorted him to the smoking courtyard. Each time he reeducated him but never followed up as he assumed Resident #3 did not supervision when he smoked. He further stated that he told Resident #3 if he continued to smoke in nondesignated areas, he would have to be supervised when he smoked. The Assisted Living Director stated before the incident with the burned mattress on 10/21/14, he had been told staff found lighters and cigarette butts on him but he denied being told the resident was smoking inside the building. He stated he recalled MT #1 telling him about Resident #3 having lighters twice. The Assisted Living Director stated he never investigated where he got the lighters but suspected he got them when he went out with a friend. He never met or spoke to the friend who took Resident #3 out of the facility. After the mattress was burned there were no changes made relating to resident #3's supervision as staff had collected all smoking materials, knew to keep their eye on him and knew he was scheduled to transfer per his own choice to another facility. The Assisted Living Director stated he did not deal with smoking issues and concentrated his efforts on census development. The Assisted Living Director stated he did not know why he did not tell the Administrator about the episodes of Resident #3 smoking in the nonsmoking areas and having lighters and cigarettes on him.

On 12/08/14 at 3:13 PM, Interview with the Director of Nurses and the Administrator revealed neither were aware of any unsafe smoking practices or violations to the smoking policy relating to Resident #3 prior to being informed that the resident had burned a hole in his

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D 270	Continued From page 13 mattress on 10/21/14. They stated after the 10/21/14 incident, the family was notified, a search of his room had been done and staff noted the resident was educated about the smoking policy. The Administrator stated Resident #3 was not permitted to keep smoking materials in his room and they should have been kept at the nursing station. The Administrator stated that the proper protocol was to notify administration of residents being noncompliant with the smoking rules. Follow-up interview with the Administrator on 12/08/14 at 5:26 PM revealed if a resident needed supervision during smoking, they were permitted to go out only at designated smoking times as listed on the staff assignment sheets (8:30 AM, 10:30 AM, 1:30 PM, 3:30 PM, 6:30 PM and 8:30 PM). The Administrator stated her expectation was that if a resident was not smoking in the designated areas or following the policy, the event was to be documented, she was to be notified, the resident was to be reassessed for needs, the care plan was to be reviewed and revised, the resident was to be educated, communication of changes was to be made to staff and the resident was to be monitored. In addition, the resident would be warned of consequences and discharge would be initiated if necessary. The Administrator further stated on 12/09/14 at 11:18 AM during an interview that she did not personally speak to the resident after the burned mattress incident as she knew his smoking materials had been removed and he was being transferred to another facility. On 12/09/14 at 2:48 PM the courtyard off the activity room nearest the skilled nursing station was identified by staff as the smoking area. On 12/10/14 at 8:00 AM the 2 courtyards were observed. In the courtyard closed to the skilled nursing station, outside the activity room there	D 270		

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were multiple ashtrays, however, no sign designating this as a designated smoking area. Observation of the other courtyard revealed no ashtrays and no signs indicating this was a nonsmoking area.

Resident #3 was discharged from the facility to another assisted living facility per his request on 10/23/14.

The Administrator was notified of the Type A2 Violation under the Adult Care Home Licensure Rules 10A NCAC Subchapter 13F .0901 (b) on 12/09/14 at 1:30 PM.

The facility provided an acceptable Allegation of Compliance on 12/10/14 at 1:00 PM as follows:

The allegation of compliance is filed as evidence of the facility ' s desire to comply with the requirements and to continue to provide high quality of care.
· For Resident #3, the resident voluntarily transferred from the facility to another Assisted Living facility on October 23, 2014. There were no other residents who smoke in the Assisted Living.
· The Smoking Policy was revised on December 9, 2014 with changes including assessment for safe smoking on admission, quarterly, and with a change in condition, all smoking paraphernalia will be secured at the nurses station, the facility reserves the right to search a resident ' s belongings for smoking materials, and any residents not abiding by the smoking policy and deemed to be putting themselves or others in danger will be given a 30-day discharge notice.
· The Resident Handbook was updated to reflect the smoking policy changes. The Smoking

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D 270	Continued From page 15 Policy will be reviewed with the resident and responsible party upon admission by the Assisted Living Coordinator or Admissions Director. · Any new admissions will have the Smoking Risk Assessment completed within 24 hours of admission by the admitting nurse. Completion of the assessment will be monitored by the Director of Nursing. The assessing nurse will immediately document if the resident is a safe or supervised smoker on the " Standards of Care " communication form. This form is kept at the nurses stations and identifies the individual needs of each resident. During weekly interdisciplinary meetings, each resident ' s smoking status is reviewed and any changes are updated by the Administrator. The Smoking Risk Assessment will be completed quarterly thereafter and with any change in the resident ' s condition by the charge nurse and any changes documented in the " Standards of Care. " · Individualized smoking care plans will be developed by the admitting nurse within 24 hours of admission to be reviewed by the MDS Coordinator or Director of Nursing. · Newly admitted residents who smoke will be monitored by the charge nurse via the " Smoking Compliance Monitoring Tool " for 72 hours and weekly thereafter for 2 weeks. The monitoring includes that the resident can verbalize the highlights of the smoking policy, has returned their smoking materials to the nurses station, has smoked only in designated areas, and has not given any smoking paraphernalia to other residents. · All residents smoking materials will be kept secure at the nurses station. Residents who are assessed to be a safe smoker will sign their smoking materials in and out via the Smoking Material Sign Out/ In form maintained at the nurses station. Any nursing staff can sign	D 270		

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smoking materials in and out for residents.

· Education was provided to the Assisted Living Coordinator on December 10, 2014 by the Administrator regarding the smoking policy revisions, reviewing the smoking policy upon admission, the " Standards of Care, " the Smoking Risk Assessment, notifying the Administrator of any resident ' s non-compliance with the smoking policy, the facility may search the resident ' s belongings for smoking materials, and any non-compliance will result in a 30-day discharge notice.

· Education was provided to all staff including contract staff by the Staff Development Coordinator regarding the revised smoking policy, completion of the Smoking Risk Assessment, completion of individualized care plans, designated smoking areas, smoking materials are kept secure at the nurses station, Standards of Care, and the Smoking Compliance Monitoring Tool. This in-service began on December 9, 2014 and will be provided to all staff prior to the start of their shift until 100% of staff are trained. No staff will be allowed to work prior to receiving in-service training.

The Type A violation was removed on 12/10/14 at 1:30 PM when interviews with nursing staff, non-nursing staff and contract staff confirmed they had received inservice training on the facility's smoking policy and procedures and the expected action to take when a resident was found not to follow the smoking policy. Nursing staff confirmed knowledge of the need for smoking assessments and care plans. A system was observed in place to identify the residents who smoked and their needed supervision requirements. A system was observed in place to secure all smoking materials. All staff interviewed knew the location of the designated

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D 270	Continued From page 17 smoking courtyard. Signs were observed in place distinguishing the courtyard designated for smoking. There were no current rest home residents who smoked at the time of exit. The facility remains out of compliance in order to ensure continued education and monitoring of the plan of correction.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Cross Refer to 10A NCAC 13F .0901 Personal Care and Supervision Based on observations, policy review, record review and staff interviews, the facility failed to assess and care plan smoking supervision needed, communicate changes in the supervision needed, and supervise 1 of 1 sampled resident who required supervision when smoking. In addition, the facility failed to implement their policy related to keeping smoking materials secured and posting signs designating the smoking area. Resident #3 was found with smoking materials and smoking in his bed during which he burned a hole in his mattress.	D 338	Filing the plan of correction does not constitute admission that the deficiency alleged did in fact exist. The allegation of compliance is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. " For Resident #3, the resident voluntarily transferred from the facility to another Assisted Living facility on October 23, 2014. There were no other residents who smoke in the Assisted Living. " The Smoking Policy was revised on December 9, 2014 with changes including assessment for safe smoking on admission, quarterly, and with a change in condition, all smoking paraphernalia will be secured at the nurses station, the facility reserves the right to search a	12/23/14

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D 338	Continued From page 18	D 338	resident□s belongings for smoking materials, and any residents not abiding by the smoking policy and deemed to be putting themselves or others in danger will be given a 30-day discharge notice. " The Resident Handbook was updated to reflect the smoking policy changes. The Smoking Policy will be reviewed with the resident and responsible party upon admission by the Assisted Living Coordinator or Admissions Director. " Any new admissions will have the Smoking Risk Assessment completed within 24 hours of admission by the admitting nurse. Completion of the assessment will be monitored by the Director of Nursing. The assessing nurse will immediately document if the resident is a safe or supervised smoker on the Standards of Care communication form. This form is kept at the nurses stations and identifies the individual needs of each resident. During weekly interdisciplinary meetings, each resident□s smoking status is reviewed and any changes are updated by the Administrator. The Smoking Risk Assessment will be completed quarterly thereafter and with any change in the resident□s condition by the charge nurse and any changes documented in the Standards of Care. " Individualized smoking care plans will be developed by the admitting nurse within 24 hours of admission to be reviewed by the MDS Coordinator or Director of Nursing.	

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D 338	Continued From page 19	D 338	" Newly admitted residents who smoke will be monitored by the charge nurse via the Smoking Compliance Monitoring Tool for 72 hours and weekly thereafter for 2 weeks. The monitoring includes that the resident can verbalize the highlights of the smoking policy, has returned their smoking materials to the nurses station, has smoked only in designated areas, and has not given any smoking paraphernalia to other residents. " All residents smoking materials will be kept secure at the nurses station. Residents who are assessed to be a safe smoker will sign their smoking materials in and out via the Smoking Material Sign Out/ In form maintained at the nurses station. Any nursing staff can sign smoking materials in and out for residents. " Education was provided to the Assisted Living Coordinator on December 10, 2014 by the Administrator regarding the smoking policy revisions, reviewing the smoking policy upon admission, the Standards of Care, the Smoking Risk Assessment, notifying the Administrator of any resident□s non-compliance with the smoking policy, the facility may search the resident□s belongings for smoking materials, and any non-compliance will result in a 30-day discharge notice. " Education was provided to all staff including contract staff by the Staff Development Coordinator regarding the revised smoking policy, completion of the Smoking Risk Assessment, completion of individualized care plans, designated	

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D 338	Continued From page 20	D 338	smoking areas, smoking materials are kept secure at the nurses station, Standards of Care, and the Smoking Compliance Monitoring Tool. This in-service began on December 9, 2014 and will be provided to all staff prior to the start of their shift until 100% of staff are trained. No staff will be allowed to work prior to receiving in-service training. " An audit tool was developed to include the following: o Was the Smoking Risk Assessment completed upon admission and were the results communicated via Standards of Care? o Has there been a change in condition? If so, was the Smoking Risk Assessment completed and results communicated via Standards of Care? o Was an appropriate care plan initiated and updated with any changes? o If the resident requires supervision, is proper supervision being provided at designated times? 100% of all new admissions and all current residents that smoke will be audited for compliance. Audits will be completed by the Director of Nursing or RN Supervisor weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. All audit information will be analyzed and reviewed by the Director of Nursing at the QAPI Committee Meetings.	