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	345351	A. BUILDING _____ B. WING _____	C 06/23/2017

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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 170 SS=C	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail to residents in the facility on Saturday. Findings included:	F 170	Preparation and submission of the POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	7/15/17

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

Electronically Signed | 07/19/2017

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F 170	Continued From page 1 During an interview on 06/22/17 at 9:34 AM the Resident Council President stated mail was delivered to residents Monday through Friday but it was not delivered to them on Saturday. She further stated she did not know why mail was not delivered on Saturday because there was a local post office. She explained if she were living at home she would get mail delivered on Saturdays and it was important for her to receive mail each day the post office was open to deliver mail. During an interview on 06/23/17 at 8:46 AM the Social Worker stated mail was delivered to residents from Monday to Friday each week and the Activity Director or her assistant distributed mail to residents. She explained they did not have staff in the front office to get the mail for residents on Saturday. During an interview on 06/23/17 at 9:12 AM the Business Office Manager stated the post office delivered mail to the facility to a mail box outside the front door of the facility Monday through Friday. She explained a receptionist went and got the mail out of the mailbox between 10:00 AM and 11:00 AM and the Activity Director or her assistance distributed mail to residents. She stated the facility had asked the post office to not deliver mail on Saturday because they got checks in the mail and they did not want checks sitting in the mailbox on the weekend because they did not have a receptionist on the weekends. During an interview on 06/23/17 at 10:40 AM the Administrator stated she had just learned mail was not delivered to the facility on Saturday. She stated it was her expectation for mail to be delivered to residents every day the post office	F 170	It has been identified that the facility failed to deliver mail to residents on Saturdays. This company does have a policy to ensure that this standard is met. For all residents affected & for those with the potential to be affected by the alleged deficient practice the following has been achieved: The facility administrator takes full responsibility to insure mail delivery occurs on Saturday. On 6/26/2017 the USPS was contacted by the Human Resources Director with instruction to provide Saturday mail delivery to the facility beginning 7/15/17. The dayshift nurse working E-hall is to check the mailbox for deliveries. The same licensed nurse is to ensure a timely receipt of unopened mail to residents. In-service of process provided to all nursing staff on 7/14/17 by Assistant Director of Nursing. Staff Development Coordinator, or designee, will audit mail delivery to ensure compliance. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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F 170	Continued From page 2 delivered mail and the problem would be corrected.	F 170		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to provide toileting to promote dignity and respect for 1 of 1 sampled resident to treat residents with dignity and respect (Resident #14). Findings included: Resident #14 was re-admitted to the facility on 12/08/15 with diagnoses which included anemia, heart failure, asthma, anxiety disorder and paralysis in upper and lower extremities. A review of the most recent quarterly Minimum Data Set (MDS) indicated Resident #14 was cognitively intact for daily decision making. The MDS also indicated Resident #14 required extensive staff assistance with activities of daily living (ADL) and was frequently incontinent of bladder and bowel. A review of a care plan indicated Resident #14 had an ADL self-care performance deficit and the goal indicated Resident #14 would maintain current level of function in through the review date. The interventions revealed in part Resident #14 required 1 staff member participation with	F 241	It has been identified that the facility failed to provide toileting to promote dignity & respect for resident #14. This company does have a policy to ensure this standard is met. The Director of Nursing takes full responsibility to insure that residents are treated with dignity and respect of individuality. For resident affected: After the surveyor reported this occurrence disciplinary action was taken against the NA assigned to the resident #14□s care for failure to observe facility protocol. A review of call light policy was performed with all nursing staff by the Director of Nursing; with emphasis that all members of the nursing staff are expected to answer call lights. For residents potentially affected: Because all residents are potentially affected by the alleged deficiency, the facility□s call light policy was revised on	7/17/17

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F 241	Continued From page 3 personal hygiene and toileting and Resident #14 would alert staff each time she had to use toilet. A review of a care plan indicated Resident #14 was at risk for infection related to a history of multiple urinary tract infections (UTIs) and the goal was Resident #14 would remain free of signs and signs and symptoms of infection through next review. The interventions were listed in part to assess Resident #14 for signs and symptoms of urinary tract infection and to report signs and symptoms of infection to the physician. During an interview on 06/22/17 at 9:34 AM Resident #14 stated last night on 06/21/17 they had a church activity scheduled for 7:00 PM she wanted to attend. She explained she turned her call light on at 6:00 PM and about 6:05 PM the Nurse Supervisor came into her room and said a Nurse Aide (NA) would be in right away but the NA did not come. She stated at 6:25 PM she turned on her call light again because she was in a mess and needed to be changed. She further stated at 6:35 PM she pleaded for someone to please take her to the bathroom and she yelled out for someone to come but nobody came. She explained at 6:50 PM a NA finally came and helped her to the bedside commode and then cleaned her. She further explained it was important for her to have assistance with toileting because she had a history of UTIs and she did not want to be left sitting in urine or feces because that caused her to have UTIs. She stated it was a regular occurrence for her to have to wait on staff to assist her with toileting and she had a clock on the wall and a watch where she could see the time it took for staff to respond. She further stated it was degrading for her to sit or lay in urine or feces and it made her feel like	F 241	6/30/17 & an in-service performed by the Director of Nursing. Additionally on 7/6/17 nursing staff were in-serviced on the new requirement to sign in/out for breaks from the assigned unit to help ensure adequate coverage of resident needs. To monitor continued compliance with these standards the following initiatives will be implemented beginning 7/17/17: call bell audits performed weekly x 4 over all shifts; random interviews of resident□s trice weekly x 4. The audits will be repeated again in 3 & 6 months. These initiatives will be performed by the Staff Development Coordinator, or designee, with any deficiencies being immediately addressed. Staff Development Coordinator, or designee, records then reports findings to the QA committee. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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staff did not care enough to take care of her properly. She also stated she talked and interacted with staff but it was hurtful to her when staff did not respond to her call bell or assist her with toileting.

During an interview on 06/22/17 at 4:11 PM with NA #3 she stated she was working on an adjacent hall when Unit Manager #1 told her Resident #14 had called for assistance to the bathroom during second shift on 06/21/17. She explained she was not assigned to Resident #14's care but NA #4 was assigned to Resident #14's care. She explained when Resident #14 called for assistance NA #4 took another resident to the shower. NA #3 stated she told Unit Manager #1 she had to finish assisting another resident and then she went to Resident #14's room and assisted her to the bathroom. She confirmed she did not recall if Resident #14 was soiled with feces but she was wet and she cleaned and changed her.

During a telephone interview on 06/22/17 at 9:17 PM with NA #4 she confirmed she was assigned to care for Resident #14 on 06/21/17 on second shift but thought around 6:00 PM she was with another resident. She explained she recalled she assisted Resident #14 with toileting later in the evening and Resident #14 was wet and she cleaned and changed her.

During an interview on 06/23/17 at 10:56 AM the Director of Nursing stated all staff could answer call lights but not all staff could assist the resident. She explained she expected for staff to answer the call light and if they could not take care of the problem they should to go find someone to let them know the resident's light was

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F 241	Continued From page 5 on. She stated she would have expected for staff to respond to Resident #14's call light and assist her with toileting sooner. During a telephone interview on 06/23/17 at 11:03 AM with Unit Manager #1 she verified she answered Resident #14's call light on 06/21/17. She stated she did not recall the exact time but thought it was around supper time. She stated she told Resident #14 she would find a NA to assist her. She confirmed NA #4 was assigned to Resident #14's care but she was not sure where NA #4 was when Resident #14 needed help with toileting. She stated she told NA #3 Resident #14 needed toileting and NA#3 assisted Resident #14. During an interview on 06/23/17 at 11:56 AM the Administrator stated it was her expectation for staff to answer call lights promptly and residents should not have to wait for care. She explained Resident #14 was close to the staff and she was surprised Resident #14 had to wait for staff to assist her with toileting. She stated if her assigned NA was giving another resident a shower, there were other staff who could have responded more quickly to provide care to her and stated it was her expectation for staff to treat residents with dignity and respect.	F 241		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	F 282		7/20/17

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F 282	Continued From page 6 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to follow the care plan for smoking safety for 2 of 2 residents (Resident #28, Resident #43). Findings included: 1. Resident #28 was admitted to the facility on 05/12/09 with the diagnoses of schizophrenia, bipolar disorder, and nicotine dependence. A review of the most recent annual Minimum Data Set (MDS) dated 04/02/17, indicated Resident #28 was cognitively intact and did not reject care. A review of the care plan dated 04/12/17 focused on Resident #28 being a supervised smoker and must keep smoking materials at the nursing station. The interventions put in place were cigarettes, lighters, and matches be kept by the appropriate staff only. The goal was for Resident #28 to enjoy tobacco safely in accordance to the smoking policy. An observation of Resident #28 in his room was made on 06/20/17 at 2:54 PM and revealed a cigarette was laying on the nightstand and 2 cigarette lighters were in a zipped pouch. During an interview conducted on 06/20/17 at 2:58 PM, Resident #28 confirmed staff had not provided the cigarette, but it was provided by another resident. Resident #28 also confirmed the 2 lighters had been kept in the zipped pouch and was not able to recall for how long, but stated, "I had the lighters a long time."	F 282	It has been identified that the facility failed to update the care plan for smoking for 2 residents identified. For residents #28 and #43 care plan was updated on 6/21/2017 by social worker. All smoking care plans have been updated. Smoking materials were removed from each residents room by social worker on 06-21-17. Current residents who smoke, rooms were checked with resident present to ensure they did not have any smoking material in their room/possession on 06/21/2017. Current residents who smoke have had new smoking assessment completed 06/22/2017. Current residents who smoke have signed new contracts and reviewed updated smoking care plans by 06/22/2017. Current residents who smoke will have rooms checked periodically by social worker to ensure no smoking materials are in their possession. Current residents who smoke will have group meeting to be reeducated on facility policy on 06/23/2017, 06/26/2017, and 06/29/2017. Responsible Party of Current residents who smoke were notified by 06/22/2017 of policy and contract agreement, as well as updated smoking care plan by social	

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F 282	Continued From page 7 During an interview conducted on 06/20/17 at 3:25 PM with NA #2 who confirmed it was not allowed for residents to have cigarettes and lighters in their room and the resident could lose their smoking privileges. During an interview conducted on 06/21/17 at 09:51 AM with the Administrator and the Director of Nursing (DON) who confirmed residents were to get their smoking materials from the nurse staff at nursing station. The supervised smoking residents are accompanied by a designated staff member who is in charge of the smoking materials during supervision and is to return them to the nursing station. The supervised smokers should never have smoking materials. During an interview conducted on 06/21/17 at 10:03 AM with the Social Worker (SW) who confirmed smoking residents were not allowed to keep smoking materials in their room at any time. A second interview was conducted with the SW on 06/21/17 at 12:00 PM who revealed Resident #28's care plan was last updated on 04/03/17 and read as he is a supervised smoker. During an interview conducted on 06/23/17 at 9:47 AM with the DON who revealed her expectations of staff were for residents' smoking materials be secured at the nursing stations and signed in and out. 2. Resident #43 was admitted to the facility on 11/22/16 with diagnoses which included chronic lung disease, tobacco use, and history of lung cancer. The admission Minimum Data Set (MDS) dated for 11/29/16 indicated Resident #43 required extensive assistance with bathing and only supervision for all other activities of daily living (ADL). The MDS also indicated Resident	F 282	worker. Social worker is responsible to ensure care plans are updated related to residents smoking status. Social worker received education on 7/20/2017 by MDS coordinator related to updating care plans accordantly. MDS coordinator will audit smoking care plans of residents who smoke to insure status is updated with current assessment. Audits will be does weekly x 3 then monthly x 3. Any areas identified will be addressed at that time. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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#43 had current tobacco use but had not used oxygen. Review of the smoking care plan initiated 11/22/16 indicated Resident #43 was a safe smoker. Goals included maintain a safe smoking environment as evidenced by no smoking violations through the next review, follow tobacco policy without injuring self or others and being able to enjoy tobacco safely in accordance with policy. Some of the Interventions included completing room searches for smoking items if warranted for safety, educating resident about smoking risks, hazards and about smoking aides if applicable, and staff to keep tobacco products, cigarettes, lighters, matches etc. in designated location and dispense during smoking times.

Review of the Smoking Contract governing the regulations for the use and possession of smoking materials was signed by Resident #43 on 06/08/17 and indicated the following under Resident Rules and Regulations:

5. "Residents residing in the long-term care units are prohibited from keeping smoking materials in their rooms or in their possession and smoking materials, cigarettes, and lighters must be kept secured by facility."

Review of the most recent smoking assessment (SA) for Resident #43 that was completed on 06/21/17 indicated Resident #43 was identified as a safe smoker. The SA also identified Resident #43 could smoke unsupervised in the designated smoking areas but must request her smoking materials from staff.

During an interview in the bedroom of Resident #43 on 06/19/17 at 11:15 AM, Resident #43 stated she was a smoker but because she was

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considered a safe smoker she could smoke whenever she chose to. Resident #43 also stated she did not keep her cigarettes or lighters with her. Resident #43 further stated her smoking material was kept at the nurses' station. During this interview 2 cigarette lighters were observed on the nightstand beside the bed of Resident #43.

During an observation on 06/20/17 at 3:08 PM Resident #43 was observed with a lighter on her nightstand beside the bed.

During an observation on 06/20/17 at 3:11 PM Resident #43 was observed going outside the doorway leading to the courtyard where smoking was allowed. Resident #43 was observed removing a pack of cigarettes from an area beneath the front of her blouse, took a cigarette out along with a lighter, and offered a cigarette to another resident sitting outside in a wheelchair. The other resident took the cigarette but was not observed lighting it or having it lit for her. Resident #43 was observed lighting her own cigarette then putting the lighter in her left front pants pocket and the pack of cigarettes was put in an area beneath the front of her blouse. A continuous observation of Resident #43 was made until she reentered the facility and went straight to her bedroom with the pack of cigarettes and the lighter with her. No staff were observed going into her room to request her smoking materials and Resident #43 did not attempt to take them to the nurse's station.

During an interview on 06/21/17 at 9:45 AM the Administrator (ADM) stated that residents will sometimes "sneak cigarettes and lighters" into their rooms. The ADM also stated the

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independent smokers are supposed to come and get their smoking materials from the nurse at the nurses' station and when they come back in the residents are supposed to return the remaining smoking materials back to the nurse. The ADM further stated this was an honor system for the independent smokers.

During an interview on 06/21/17 at 10:01 AM the Social Services Director (SSD) stated she was responsible for posting lists at the nursing stations for residents who were the supervised and the unsupervised smokers. The SSD also stated the supervised residents were not allowed to have their smoking materials on them nor are they supposed to light their own cigarettes. The SSD further stated she would have concerns if any resident gave another resident cigarettes.

On 06/21/17 at 10:20 AM the ADM and SSD were observed entering the bedroom of Resident #43 and asked her if she had any smoking materials in her room. Resident #43 stated she didn't and the SSD asked if it would be okay if they completed a room search and Resident #43 stated yes. Resident #43 was found to have 3 lighters in a baggie in her room and stated she had just found them yesterday. The SSD explained to Resident #43 that her smoking material was supposed to be kept up at the nurses' station but she could request it at any time. Resident #43 became visible upset, raising her voice and became tearful, stating that was too far for her to walk.

During an interview on 06/21/17 at 4:12 PM Nurse #1 verified by reviewing physician's orders that Resident #43 only used nebulized treatments and did not have an order for oxygen. Nurse #1

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stated she had never seen Resident #43 use oxygen and was not aware that she kept her cigarettes or lighters on her. Nurse #1 also stated although Resident #43 was considered a safe smoker she would be concerned if Resident #43 was giving other residents cigarettes or keeping her smoking material in her room.

During an interview on 06/22/17 at 10:13 AM Nurse #2 stated she had not worked with Resident #43 in over a month but she used to check her oxygen saturation and if it was below 92%, there was a standing order to put her oxygen on. Nurse #2 stated that she had in the past placed oxygen on Resident #43 due to an oxygen saturation of less than 92% but it had been over a month ago. Nurse #2 also stated she had never seen Resident #43 with smoking materials in her room and that is was an honor system for the residents to return the smoking materials back to the nursing station when they came back inside from smoking.

During an interview on 06/22/17 at 1:16 PM the Medical Director (MD) he stated that he was aware Resident #43 was a smoker and had talked with her about smoking cessation but she had no interest in stopping smoking. The MD stated he would "definitely be concerned" if she was keeping smoking materials in her room. The MD also stated due to some of the diagnoses of Resident #43 she may try to smoke in her bathroom or try to smoke in bed.

During an interview on 06/22/17 at 3:53 PM NA #1 indicated she had worked with Resident #43 for the past 3 days. NA #1 stated she had never seen Resident #43 with cigarettes or lighters in her room and Resident #43 or any other resident

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F 282	Continued From page 12 had ever asked her to put their cigarettes or lighters back up at the nurse's station. During an interview on 06/22/17 at 4:22 PM the DON acknowledged she expected the care plan to be followed even though she stated they were not aware that Resident #43 was keeping lighters and cigarettes with her.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to clean debris from underneath the fingernails of a dependent resident for 1 of 4 residents reviewed for activities of daily living (Resident #30). Findings included: Resident #30 was admitted to the facility on 07/15/09 with diagnoses of Alzheimer's, dementia, and glaucoma. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/19/17 indicated Resident #30 was severely cognitively impaired and had no rejection of care. The MDS indicated Resident #30 required extensive assistance with personal hygiene and total assistance with bathing. The MDS also indicated the resident needed extensive assistance with transfers, walking did not occur and a wheelchair was used for mobility.	F 312	It has been identified that the facility failed to clean debris from underneath the nails of a dependent resident. The company does have a policy to prevent these findings. The Director of Nursing takes full responsibility to ensure ADL care is provided for dependent residents. Resident affected: As documented in affected resident #30□s EMR, she is resistant to care &/or assistance with ADL□s. There is a care plan in place reflective of this & a progress note dated 6/23/17 which documents an unsuccessful attempt by staff to provide nail care. Resident□s nails have been successfully cleaned on shower dates since finding.	7/17/17

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F 312	Continued From page 13 A review of the care plan for Resident #30 dated 05/01/16 focused on a deficit with activities of daily living (ADL) related to a diagnosis of altered mental status. The interventions related to nail care were check nail length and trim and clean on bath day and as necessary. The care plan also focused on staff assisting with personal hygiene and setting up the meal tray's and revealed Resident #30 would independently eat finger foods. An observation of Resident #30 on 06/19/17 at 11:29 AM revealed brown debris under the left hand fingernails included the middle fingernail and index fingernail and thumb fingernail. The right hand revealed brown debris under the index fingernail, middle fingernail, ring fingernail, and pinky fingernail. An observation of Resident #30 on 06/20/17 at 04:23 PM revealed brown debris remained under the left and right hand fingernails. An observation of Resident #30 on 06/21/17 at 04:58 PM revealed brown debris was still present under the left and right hand fingernails. An observation of Resident #30 on 06/22/17 at 11:07 AM revealed the brown debris remained under the left and right hand fingernails. An interview was conducted on 06/22/17 at 4:17 PM with Nurse Aide (NA) #4 who indicated she had provided Resident #30 a shower the previous night along with nail care the morning prior to the shower. NA #4 confirmed Resident #30 had brown debris underneath the fingernails on both hands. She revealed Resident #30 ate using her fingers at times and the brown debris could be	F 312	For resident affected & resident□s potentially affected: Because any resident requiring assistance with ADL care could potentially be affected by the alleged deficiency cited on 6/23/17 the following practice was implemented on 7/14/17: disposable personal washcloths are available on each nursing unit & in each dining hall which should be used to provide hand hygiene, including under nails, prior to consumption of meals. An in-service of this practice was completed on 7/14/17 by the Assistant Director of Nursing. To ensure compliance of nail care standards the following initiatives will be implemented 7/17/17 & performed by the Staff Development Coordinator, or designee: nail audits weekly x 4 then monthly thereafter; random spot checks at meal service to ensure resident□s hand hygiene trice weekly x 4 then monthly thereafter. Any deficiencies will be addressed immediately. Staff Development Coordinator, or designee, records then reports findings to the QA committee. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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F 312	Continued From page 14 food. An interview was conducted on 06/22/17 at 4:27 PM with Nurse #5 who confirmed Resident #30 had brown debris underneath the fingernails on both hands and did not appear they had been cleaned. Nurse #5 also confirmed Resident #30 did not refuse care. An interview was conducted on 06/22/17 at 4:41 PM with the Director of Nursing who confirmed Resident #30's fingernails were very dirty and her expectations were for fingernails to be cleaned as needed when dirty or soiled.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		6/29/17

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F 323	Continued From page 15 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to supervise a resident requiring supervision during smoking and failed to keep smoking materials in a safely stored area by the appropriate staff for 2 of 6 residents (Resident #28, Resident #43). Findings included: 1. Review of the facility smoking policy revised on 04/28/17 read in part resident smoking materials will be retained and distributed by the facility staff to the residents during the designated smoking times and/or when independent resident choses to smoke. No resident is permitted to maintain or store smoking materials on their person or in their room. Review of a smoking contract dated 05/24/17 read in part the resident agrees and acknowledges that sharing cigarettes may compromise the health and welfare of other resident's and presents a safety hazard at the facility and thus agrees not to share cigarettes with other residents. Residents are prohibited from keeping smoking materials in their rooms or in their possession and smoking materials, cigarettes and lighters must be kept secured by the facility. The facility will conduct room searches for cigarettes and smoking materials in the presence of the resident or responsible party. The contract had been signed by Resident #28.	F 323	It has been identified the facility failed to supervise residents requiring supervision during smoking and failed to keep smoking materials safely stored for 2 residents. The administrator takes full responsibility to ensure that residents' environment is free of accidents, hazards. For resident #28 and resident #43 smoking materials were removed by social worker on 6/21/17. Current residents who smoke, rooms were checked by social worker & regional nurse with resident present to ensure they did not have any smoking material in their room/possession on 06/21/2017. Social worker completed smoking assessment on current resident's who smoke on 6/22/2017. Social worker assisted current residents who smoke to sign new smoking contracts on 06/22/2017. Current residents who smoke will have rooms checked periodically by social worker to ensure no smoking materials are in their possession. Current residents who smoke had a group meeting held by social worker and regional nurse to be reeducated on facility policy on 06/23/2017, 06/26/2017, and 06/29/2017.	

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F 323	Continued From page 16 Resident #28 was admitted to the facility on 05/12/09 with the diagnoses of schizophrenia, bipolar disorder, and nicotine dependence. A review of the most recent annual Minimum Data Set (MDS), dated 04/02/17, indicated Resident #28 was cognitively intact with behavior symptoms of scratching or hitting himself, pacing, and rummaging. The MDS noted Resident #28 needed limited assistance with one person physical assistance for locomotion on and off the unit and used a wheelchair for mobility. A review of the care plan dated 04/12/17 focused on Resident #28 being a supervised smoker and must keep smoking materials at the nursing station. The interventions put in place were cigarettes, lighters, and matches be kept by the appropriate staff only and to orient and review the smoking policy and times and places to smoke. The goal was for Resident #28 to enjoy tobacco safely in accordance to the smoking policy. Review of a smoking assessment dated 06/16/17 read in part an unsafe smoking incident occurred when Resident #28 enabled a supervised smoker to smoke with no staff present. The evaluation of the incident had determined Resident #28 must be supervised by staff when smoking and must wear a smoking apron at all times and must request smoking materials from staff. A review of the supervised smokers list revealed as of 06/16/17 Resident #28 was a supervised smoker and must wear a smoker's apron. An observation of Resident #28 made on 06/19/17 at 12:46 PM revealed he was smoking unsupervised with no staff member present and was not wearing a smoker's apron and was	F 323	Responsible Party of Current residents who smoke were notified on 06/22/2017 of policy and contract agreement by social worker. Staff were in-serviced by Social Worker related to smoking policy by 06/22/2017. Unsupervised residents have begun utilizing sign out/sign in sheet for smoking materials which are now kept in a locked box with the smoking materials at each nurse□s station with one lighter available per box 06/26/2017. Current residents who smoke will have room checked weekly x 3 weeks then randomly thereafter by social worker or designee and 1 other staff member. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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flicking cigarette ashes on ground.

An observation of Resident #28 in his room was made on 06/20/17 at 2:54 PM and revealed a cigarette was laying on the nightstand and 2 cigarette lighters were in a zipped pouch.

During an interview conducted on 06/20/17 at 2:58 PM, Resident #28 confirmed being changed from an unsupervised smoker to a supervised smoker for the incident dated on 06/16/17 for providing a lit cigarette in the designated smoking area to another supervised smoking resident when staff were not present. Resident #28 also confirmed staff had not provided the cigarette observed on the nightstand and it was provided by another resident. Resident #28 confirmed smoking materials had been kept in his room and the smoking policy was unclear due to being allowed to smoke unsupervised at times. Resident #28 did confirm knowing the smoking policy related to smoking materials being returned to the nursing station.

During an interview conducted on 06/20/17 at 3:25 PM with NA #2 who confirmed staff were provided a list of supervised and unsupervised smokers at the nursing stations. NA #2 revealed residents are supposed to return their cigarettes and lighters back to nursing staff, but sometimes take their smoking materials back to their room. It is not allowed for them to have cigarettes and lighters in their room and the resident could lose their smoking privileges.

During an interview conducted on 06/20/17 at 4:00 PM with Laundry Staff (LS) #1 who revealed being responsible for supervising smoking residents at designated times and days and a list

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was to be posted in the laundry room, but the list had not been posted. LS #1 also confirmed the policy was for smoking materials to be kept at the nursing station. LS #1 revealed he was unaware Resident #28 was to be supervised when smoking.

During an interview conducted on 06/20/2017 at 5:04 PM with Nurse #4 who revealed Resident #28 had been an unsupervised smoker until 06/16/17 when he had given a supervised smoker a lit cigarette and was placed on supervised smoking. Nurse #4 revealed there was a list of the supervised and unsupervised smokers at each nursing station and the supervision was rotated by staff. The cigarettes and lighters were kept at each nursing station per policy. Residents' who were unsupervised could take the whole pack of cigarettes and a lighter to the designated smoking area, but if the resident was supervised the staff member takes the smoking materials and returns them back to the nursing station. She also revealed the unsupervised smokers do not always return their smoking materials and staff continue to encourage they be returned for safe keeping. Nurse #4 revealed if no staff member was present when residents were returning smoking materials, the residents would place them on a printer located at the nursing station. She continued to reveal there was no system in place to ensure the residents are returning smoking materials and there was residents who use oxygen in their rooms and smoke.

During an interview conducted on 06/21/17 at 09:51 AM with the Administrator and the Director of Nursing (DON) who confirmed at times residents take their smoking materials back to

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their rooms. It was an honor system and there was no established way of tracking the smoking materials that were not being returned and secured. The residents were to get their smoking materials from the nurse staff at nursing station. The Administrator and DON continue to explain the smoking policy and confirm the staff was provided with a list of supervised and unsupervised smokers. The nurse gives the unsupervised residents their smoking materials (pack of cigarettes and their lighter) and when the unsupervised smoking resident returns from the designated smoking area they were to return the smoking materials back to the nurse. The supervised smoking residents are accompanied by a designated staff member who was given 2 cigarettes and lighter for the resident to smoke during the designated time. The resident must wear a smoker's apron. The supervised smokers should never have smoking materials on their person.

During an interview conducted on 06/21/17 at 10:03 AM with the Social Worker (SW) who indicated the list of unsupervised and supervised smokers were posted in the appropriate areas and given to the facility department managers to inform designated staff of the supervised smokers in the facility. The SW revealed smoking residents were not allowed to keep smoking materials in their room at any time. She monitored by checking the rooms and asking if they had any smoking materials multiple times throughout the day, but stated, "It was difficult to track". The SW confirmed it was her responsibility to assess and educate the staff, family members, visitors, and residents' the policy rules of unsupervised and supervised smoking. She explained the policy for supervised smoking

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residents and staff assigned to supervise was a designated time to smoke and the resident must wear a smoker's apron and staff must lite the cigarette. The staff were to keep the smoking materials and return to the nursing station when finished. She confirmed Resident #28 was an unsupervised smoker until 06/16/17 when he was observed to give a supervised smoker a lit cigarette and was changed to supervised smoking. A second interview was conducted with the SW on 06/21/17 at 12:00 PM who revealed Resident #28's care plan and smoking assessment was last updated on 04/03/17 and read as he was a supervised smoker. She indicated the staff and Resident #28 were informed of his current supervised smoking status and the supervised smokers list provided to staff was up to date.

During an interview conducted on 06/23/17 at 9:47 AM with the DON who revealed her expectations of staff were for residents' smoking materials be secured at the nursing stations and signed in and out. For supervised smokers the staff give the 1 cigarette at a time, lights the cigarette, and they can have 2 cigarettes for each scheduled smoke time.

During an interview conducted on 06/23/17 at 10:34 AM with the Administrator who revealed the smoking policy and procedures were not working and it was difficult to monitor smoking materials.

2. Review of the Smoking Contract governing the regulations for the use and possession of smoking materials was signed by Resident #43 on 06/08/17 and indicated the following under Resident Rules and Regulations:

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3. "The resident agrees and acknowledges that sharing cigarettes may compromise the health and welfare of other residents and presents a safety hazard at the facility and thus agrees not to share cigarettes with other residents."

5. "Residents residing in the long-term care units are prohibited from keeping smoking materials in their rooms or in their possession and smoking materials, cigarettes, and lighters must be kept secured by facility."

Resident #43 was admitted to the facility on 11/22/16 with diagnoses which included chronic lung disease, tobacco use, and history of lung cancer. The admission Minimum Data Set (MDS) dated for 11/29/16 indicated Resident #43 required extensive assistance with bathing and only supervision for all other activities of daily living (ADL). The MDS also indicated Resident #43 had current tobacco use but had not used oxygen. Review of the smoking care plan initiated 11/22/16 indicated Resident #43 was a safe smoker. Goals included maintain a safe smoking environment as evidenced by no smoking violations through the next review, follow tobacco policy without injuring self or others and being able to enjoy tobacco safely in accordance with policy. Some of the Interventions included completing room searches for smoking items if warranted for safety, educating resident about smoking risks, hazards and about smoking aides if applicable, and staff to keep tobacco products, cigarettes, lighters, matches etc. in designated location and dispense during smoking times.

Review of the most recent smoking assessment (SA) for Resident #43 that was completed on

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06/21/17 indicated Resident #43 was identified as a safe smoker. The SA also identified Resident #43 could smoke unsupervised in the designated smoking areas but must request her smoking materials from staff.

During an interview in the bedroom of Resident #43 on 06/19/17 at 11:15 AM, Resident #43 stated she was a smoker but because she was considered a safe smoker she could smoke whenever she chose to. Resident #43 also stated she did not keep her cigarettes or lighters with her. Resident #43 further stated her smoking material was kept at the nurses' station. During this interview 2 cigarette lighters were observed on the nightstand beside the bed of Resident #43.

During an observation on 06/20/17 at 3:08 PM Resident #43 was observed with a lighter on her nightstand beside the bed.

During an observation on 06/20/17 at 3:11 PM Resident #43 was observed going outside the doorway leading to the courtyard where smoking was allowed. Resident #43 was observed removing a pack of cigarettes from an area beneath the front of her blouse and removed a cigarette for herself, offered a cigarette to another resident, and lit her own cigarette. Resident #43 was observed putting the lighter in her left front pants pocket and the pack of cigarettes was put in an area beneath the front of her blouse. A continuous observation of Resident #43 was made until she reentered the facility and went straight to her bedroom with the pack of cigarettes and the lighter with her.

During an interview on 06/20/17 with Resident

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#43 after she reentered the facility and went straight to her bedroom, she stated she had to wear oxygen every day at some point. Resident #43 stated she was able to put the oxygen on herself. The oxygen concentrator is seen on the floor beside the nightstand. No sign is observed outside the door to alert others for no smoking because oxygen is in use in the room.

During an interview on 06/21/17 at 9:45 AM the Administrator (ADM) stated that residents will sometimes "sneak cigarettes and lighters" into their rooms. The ADM also stated the independent smokers are supposed to come and get their smoking materials from the nurse at the nurses' station and when they come back in the residents are supposed to return the remaining smoking materials back to the nurse. The ADM further stated this was an honor system for the independent smokers.

During an interview on 06/21/17 at 10:01 AM the Social Services Director (SSD) stated she was responsible for posting lists at the nursing stations for residents who were the supervised and the unsupervised smokers. The SSD also stated the supervised residents were not allowed to have their smoking materials on them nor are they supposed to light their own cigarettes. The SSD further stated she would have concerns if any resident gave another resident cigarettes.

On 06/21/17 at 10:20 AM the ADM and SSD were observed entering the bedroom of Resident #43 and asked her if she had any smoking materials in her room. Resident #43 stated she didn't and the SSD asked if it would be okay if they completed a room search and Resident #43 stated yes. Resident #43 was found to have 3

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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F 323	Continued From page 24 lighters in a baggie in her room and stated she had just found them yesterday. The SSD explained to Resident #43 that her smoking material was supposed to be kept up at the nurses' station but she could request it at any time. Resident #43 became visible upset, raising her voice and became tearful, stating that was too far for her to walk. During an interview on 06/21/17 at 4:12 PM Nurse #1 stated although Resident #43 was considered a safe smoker she would be concerned if Resident #43 was giving other residents cigarettes or keeping her smoking material in her room. During an interview on 06/22/17 at 10:13 AM Nurse #2 stated she had never seen Resident #43 with smoking materials in her room and that is was an honor system for the residents to return the smoking materials back to the nursing station when they came back inside from smoking. During an interview on 06/22/17 at 4:22 PM the DON stated the facility policy was for all cigarettes and lighters to be kept at the nurses' station and to be returned after the residents came back inside from smoking. The DON further stated that due to this policy not being followed they will now require residents who smoke to use a sign-in sign-out sheet at the nurses station for smoking material, have the residents be re-educated on the facility policy for smoking, and sign a new smoking contract to allow to have their rooms checked periodically by the SW to ensure there were no smoking materials.	F 323		
F 328	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE	F 328		7/14/17

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F 328 SS=D	Continued From page 25 FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328		

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F 328	Continued From page 26 (i) Respiratory care, including 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. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to acquire a physician ' s order for an oxygen concentrator in use by 1 of 5 residents reviewed for following physician's orders (Resident #43). The findings included: Resident #43 was admitted to the facility on 11/22/16 with diagnoses which included chronic lung disease, tobacco use, and history of lung cancer. The admission Minimum Data Set (MDS) dated for 11/29/16 indicated Resident #43 required extensive assistance with bathing and only supervision for all other activities of daily living (ADL). The MDS also indicated Resident #43 had current tobacco use but had not used oxygen. Review of the smoking care plan initiated 11/22/16 indicated Resident #43 was a safe smoker. Goals included maintain a safe	F 328	It has been identified that the facility failed to acquire a physician□s order for an oxygen concentrator. The company does have a policy to prevent these findings. The Director of Nursing takes full responsibility to ensure treatment and care for residents with special needs. Resident affected: The oxygen concentrator was removed from resident #43□s room the same day it was reported, 6/22/17. Resident #43□s smoking status was re-evaluated by the Social Services Director. Resident affected & those potentially affected: Because any resident who smokes &/or	

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F 328	Continued From page 27 smoking environment as evidenced by no smoking violations through the next review, following the tobacco policy without injuring self or others, and being able to enjoy tobacco safely in accordance with policy. During an interview in the bedroom of Resident #43 on 06/19/17 at 11:15 AM, Resident #43 stated she was a smoker but because she was considered a safe smoker she could smoke whenever she chose to. During this interview 2 cigarette lighters were observed on the nightstand beside the bed of Resident #43. There was also an oxygen concentrator with tubing attached on the floor beside the nightstand. During an observation on 06/20/17 at 3:08 PM Resident #43 was observed with an oxygen concentrator with tubing was noted on the floor beside the nightstand. During an observation on 06/20/17 at 3:11 PM Resident #43 was observed going outside the doorway leading to the courtyard where smoking was allowed. A continuous observation of Resident #43 was made until she reentered the facility and went straight to her bedroom with her smoking materials with her. During an interview on 06/20/17 with Resident #43 after she reentered the facility and went straight to her bedroom, she stated she had to wear her oxygen every day at some point. Resident stated she was able to put her oxygen on by herself. The oxygen concentrator with tubing continued to be noted on the floor beside the nightstand. No sign is observed outside the door to alert others for no smoking because	F 328	has oxygen in use could potentially be affected by this alleged deficiency the following initiatives were made: 7/14/17 an in-service providing a review that the use of oxygen, in any form, requires a physician□s order & placement of a No Smoking Oxygen in use signage on doorway entrance; a review of the smoker□s contract & individual reassessments of all smokers in the facility by the Social Services Director completed by To monitor compliance with these standards audits will be utilized as follows: room audits will be performed weekly by the Staff Development Coordinator, or designee, who will then ensure an order & correct signage is in place if oxygen is in use; Social Services Director & one other designated staff member will perform random room audits on a weekly basis in search of smoking materials. Any deficiencies will be immediately addressed. The Social Services Director & Staff Development Coordinator will record & report findings to the QA committee. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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F 328	Continued From page 28	F 328		

oxygen is in use in the room.

During an observation on 06/21/17 at 9:29 AM Resident #43 was not observed in her bedroom but her oxygen concentrator with tubing attached could be seen from her doorway leading into her bedroom.

During an interview on 06/22/17 at 10:13 AM Nurse #2 stated she had not worked with Resident #43 in over a month but she used to check her oxygen saturation and if it was below 92%, there was a standing order to put her oxygen on at 2 liters per minutes. Nurse #2 stated the protocol also stated to check the oxygen saturation every 4 hours and as needed, adjust it accordingly, and notify the MD that oxygen had been started. Nurse #2 also stated she placed oxygen on Resident #43 due to an oxygen saturation of less than 92% but it had been over a month ago.

During an interview on 06/22/17 at 1:16 PM the Medical Director (MD) he stated that he was aware Resident #43 was a smoker and had daily inhaled breathing treatments. The MD reviewed his orders for Resident #43 and stated he had never given an order for her to be put on oxygen. The MD was unsure why Resident #43 would have an oxygen concentrator in her bedroom.

During an interview on 06/22/17 at 4:12 PM Nurse #1 stated a resident should not have an oxygen concentrator in his or her room without a physician's order. Nurse #1 also reviewed the physician's orders and verified there had not been an order for Resident #43 to have oxygen at any time since her admission.

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F 328	Continued From page 29 During an interview on 06/22/17 at 4:22 PM the DON acknowledged an oxygen concentrator should not have been in the room of Resident #43 if there was not a physician's order for one.	F 328		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		7/14/17

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F 431	Continued From page 30 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, manufacturer specifications, and facility policy, the facility failed to remove from use expired medications on 1 of 4 medication carts and 1 of 2 medication storage rooms. Findings included: Manufacturer specifications for Lantus storage per package insert included, "After its first use, don't refrigerate the Lantus. Keep it at room temperature below 86°Fahrenheit. After 28 days, throw your opened Lantus away-even if it still has insulin in it." A review of the facility's Medication Storage Policy dated 10/31/16 indicated, "The facility should ensure that medications that have been retained	F 431	It has been identified that the facility failed to remove from use an expired medication. The company does have a policy to prevent these findings. The Director of Nursing takes full responsibility to ensure drug records, labeling/storage of drugs and biological agents related to drug storage are effective to ensure standards of care are met. The vial of medication was removed immediately upon discovery on 6/21/17 by a state survey team member. Staff who had recently worked that medication cart were re-educated about the requirement of cart checks for, among other things, the presence of expired medications.	

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F 431	Continued From page 31 longer than recommended by manufacturer or supplier guidelines are stored separate from other medications until destroyed or returned to the pharmacy. Once any medication is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." An observation of the medication storage room #2 on 06/21/17 at 2:57 PM revealed 2 boxes of Acetaminophen suppository 650 milligrams (mg) expired on 04/30/17 and 1 box of Aspirin Suppository 300 mg expired on 04/30/17. Of the 2 boxes of Acetaminophen, 1 box had been opened. The box of Aspirin remained unopened. All the above expired medications were stored in the same refrigerator within proper temperature range. Interview on 06/21/17 at 3:06 PM with Nurse #1 revealed the third shift nurses conducted medication carts and medication rooms audit for expired medication nightly. The refrigerator where the expired suppositories were found used to store controlled medications and it was locked all the time. However, it had changed to non-controlled medication storage recently. The third shift nurses could have been overlooked this refrigerator during their nightly expired medication audits. An observation of the medication cart for A Hall on 06/21/17 at 3:38 PM revealed a vial of Lantus 100 units/Milliliter (ml) for Resident #50 that was opened on 05/20/17. As the label stated "Discard unused medication after 28 days", this vial of	F 431	On 7/14/17 all facility med carts were audited by a pharmacy staff member & an in-service issued by the Assistant Director of Nursing stating the 11p-7a nurse must perform nightly cart checks. To ensure compliance with this standard the Staff Development Coordinator, or designee, will perform medication cart audits weekly x 4 then monthly thereafter. Any deficiencies will be immediately addressed. The Staff Development Coordinator, or designee, will record then report audit findings to the QA committee. QA committee to review audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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F 431	Continued From page 32	F 431		

Lantus was expired on 6/17/17.

Review of the physician orders dated 03/09/17 indicated Resident #50 was prescribed with scheduled Lantus 10 units injected subcutaneously at bedtime for diagnosis of Diabetes Mellitus (DM). On 05/25/17, the order was increased to 12 units subcutaneously at bedtime.

Review of the Medication Administration Record (MAR) for Resident #50 indicated the Lantus was administered as ordered by the nursing staff after it was expired from 06/18/17 through 06/20/17. Further review of Resident #50's blood glucose (BG) levels from 06/18/17 through 06/20/17 revealed her BG levels were remained at the baseline without any significant changes.

Interview on 06/21/17 at 3:42 PM with Nurse #2 revealed that other than routine nightly audit by the third shift nurses, she would check each medication each time before administering to the resident. She had not been working at A Hall on second shift recently. She stated she was not one of the nurses who had administered this expired Lantus to Resident # 50.

In an interview conducted on 06/23/17 at 9:56 AM, Nurse #3 acknowledged he had administered the expired insulin Lantus to Resident #50 on 06/19/17 night. He admitted he had forgotten to check the expiration date for that Lantus before administration.

In an interview conducted on 06/23/17 at 11:49 AM, Director of Nursing (DON) stated that the facility had a system in place to check for expired medication nightly by third shift nurses. It was her

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F 431	Continued From page 33 expectation for all the nurses to follow facility's policy and manufacturer's recommendations to discard insulin Lantus stored in medication cart after 28 days from the date opened. On the other hand, all expired medications should be removed from its storage and returned to pharmacy.	F 431		
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to administer its resources effectively to ensure the smoking policy was followed to maintain the safety of its residents. Findings included: This tag was cross referenced to F 323. Based on observations, record reviews, resident and staff interviews, the facility failed to supervise residents requiring supervision during smoking and failed to keep smoking materials in a safely stored area by the appropriate staff for 2 of 6 residents (Resident #28, Resident #43). An interview was conducted on 06/21/17/at 9:51 AM with the facility Administrator and Director of Nursing who revealed at times residents took their cigarettes and lighters back to their rooms and there was no established tracking system in	F 490	It has been identified that the facility failed to administer its resources effectively to ensure the smoking policy was followed to maintain the safety of residents. The administrator takes full responsibility to ensure effective administration & resident's well-being in following the smoking policy. Smoking materials were removed from each residents room by social worker on 06-21-17. Current residents who smoke rooms were checked by social worker & regional nurse, with resident present, to ensure they did not have any smoking material in their room/possession on 06/21/2017. Current residents who smoke have had new smoking assessment completed by	6/26/17

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F 490	Continued From page 34 place to ensure smoking materials were being returned and secured. An interview was conducted on 06/23/17 at 10:34 AM with the facility Administrator who revealed it was her expectation that the Social Worker ensured residents could safely smoke and to keep her informed when a resident did not. The Administrator added the safe smoking procedures were not effective and it was difficult to track the residents smoking materials and the smoking policy was under review and would be revised by their cooperate office.	F 490	the social worker by 06/22/2017. Social worker assisted current residents who smoke in signing new contracts on 06/22/2017. Current residents who smoke will have rooms checked periodically by social worker to ensure no smoking materials are in their possession. Current residents who smoke will have group meeting to be reeducated on facility policy on 06/23/2017, 06/26/2017, and 06/29/2017. Responsible Party of Current residents who smoke were notified by 06/22/2017 of policy and contract agreement, by social worker. Staff were in-serviced by Social Worker related to smoking policy by 06/22/2017. Unsupervised residents have begun utilizing sign out/sign in sheet for smoking materials which are now kept in a locked box with the smoking materials at each nurse□s station with one lighter available per box 06/26/2017. Current residents who smoke will have room checked weekly x 3 weeks then randomly thereafter by social worker, or designee, and 1 other staff member. QA committee to review smoking audits weekly to evaluate effectiveness of interventions &/or the need for further corrective action until determined that substantial compliance has been achieved.	

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L410	.3201(K) Required Spaces 10A-13D. 3201 (k) The facility shall provide patient and resident storage at the rate of not less than five square feet of floor area per licensed bed. This storage space shall: (1) be used by patients and residents to store out-of-season clothing and suitcases; (2) be either in the facility or within 500 feet of the facility on the same site; and (3) be in addition to the other storage space required by this Rule. This Rule is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide at least one bathtub in operating condition. The findings included: During an observation conducted on 06/22/17 at 11:31 AM with Unit Manager (UM) #1, the bathtub in the shower room at C Hall was not in working condition. In an interview conducted with UM #1 on 06/22/17 at 11:34 AM, she stated the bathtub had not been working and she did not know how long it had been in this condition. She added there was another bathtub in D Hall. During an observation conducted on 06/22/17 at 11:49 AM, Nurse Aide (NA) #1 failed to operate the bathtub in the shower room at D Hall. In an interview conducted with NA #1, she stated she had not seen any NAs using the bathtub in D Hall since she started to work in this facility on February, 2017. She was not sure the bathtub in D Hall was still in working condition.	L410	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any court proceeding. It has been identified that this facility failed to provide at least one bathtub in operating condition. On 7/18/17 a bathtub was ordered for facility to be installed on arrival. Scheduled to be installed on 7/31/17. Once installed the Director of Maintenance will maintain & ensure working order of the tub by performing audits weekly x3 then monthly. The Administrator takes full responsibility to follow-up on any issues related to the tub's operation. QA committee to review maintenance reports weekly x 3 then monthly until it is determined substantial compliance has been achieved.	7/31/17

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

Electronically Signed | 07/20/17

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(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) COMPLETE DATE
L410	Continued From page 1 During an interview conducted on 06/22/17 at 12:23 PM with the Maintenance Manager (MM), he stated that both bathtubs were not in working condition. The bathtub in D Hall had drainage problems and the bathtub in D Hall had issues with the lifting system. The MM added he could not find any maintenance records for both bathtubs. In an interview conducted with Director of Nursing (DON), she stated both bathtubs had not been in working condition since she started to work for the facility 2 years ago. The facility was in the process of getting a new bathtub. It was her expectation for the facility to have at least one bathtub in working condition.	L410		