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	345140	A. BUILDING _____ B. WING _____	C 05/04/2018

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 5/2/18 through 5/4/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.70 at tag F835 at a scope and severity (J) The tags F689 and F835 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/23/18 and was removed on 5/4/18. An extended survey was conducted.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to protect a resident (Resident # 5) from verbal and physical	F 600	" The deficient practice is the failure to protect a resident from abuse. This practice occurred when Nurse Aide #1	5/31/18

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

Electronically Signed | 05/25/2018

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F 600	Continued From page 1 intimidation from a staff member, for one of three resident reviewed for abuse. Findings included: Resident #5 was admitted to the facility on 4/19/18 with admission diagnoses which included: Pneumonia, heart failure, diabetes, arthritis, anxiety, and depression. Resident #5's most recent Minimum Data Set (MDS) was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 4/26/18. The resident was coded as having had no cognitive loss. The resident had a Brief Interview for Mental Status (BIMS) score of 15. The resident had no behaviors coded for the assessment period. The resident was coded as requiring extensive assistance of one person for bed mobility, toilet use, and two people for transfer (i.e. from the bed to the chair). The resident was coded as having had received antidepressant medication for one day of the assessment period and no other psychotropic medications. The resident was coded as having received oxygen during the assessment period. Resident #5 had a baseline care plan in place which was most recently updated on 4/24/18. The resident's baseline care plan included the following areas: Therapy services, Activities of Daily Living (ADLs), oxygen use, incontinence, insulin use, pain, and the resident was to be long-term at the facility. Review of the physicians' orders revealed the resident had been prescribed Paroxetine 10 milligrams (mg) orally one time a day for anxiety on 4/19/18, the date of admission.	F 600	chose to disregard the training she had received on the facility□s Abuse Policy and verbally and physically intimidated resident #5. As soon as resident #5 reported the allegation of abuse, Nurse Aide #1 was placed on suspension pending investigation as required by the facility Abuse Policy and Federal Regulation. At the completion of the investigation, the facility Administrator made the decision to substantiate the allegation based on information from the investigation and terminated Nurse Aide #1 from employment at the facility. The termination of Nurse Aide #1 is the corrective action for this citation. This is also in accordance with the facility Abuse Policy and the regulations at CFR 483.12(a)(1). Resident #5 was informed of the investigation outcome and the termination of Nurse Aide #1 from employment with the facility. " Any resident may have the potential to be affected by this practice. The facility Abuse Policy outlines the various types of abuse, why abuse is not tolerated, what constitutes abuse, how and to whom to report suspected abuse, and the signs of burnout and frustration that may lead to abuse as required in CFR 483.12(a)(1). On May 21, 2018, a facility wide inservice on the Abuse Policy was conducted by Cathy Almon, Administrator and the full Abuse Policy was reviewed with staff. All staff were required to attend the inservce and each staff member was given a copy of the facility□s Abuse Policy . Staff also signed an acknowledgement page stating that they understood the facility Abuse	

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F 600	Continued From page 2 A nurses' note for Resident #5 dated 4/20/18 which was documented as a late entry for 4/19/18, the date of admission, at 9:00 PM included documentation the resident was alert and oriented and was able to verbalize needs. The resident was documented as having been observed to have no acute distress. Nurses' notes for Resident #5 dated 4/21/18, 4/22/18, 4/23/18, 4/24/18, 4/25/18, 4/26/18, 4/27/18, 4/28/18, 4/29/18, and 4/30/18 documented the resident was alert and oriented and was able to make needs known to staff. A Daily Skilled Nursing Evaluation for Resident #5 dated 4/24/18 documented the resident was alert and oriented to time, place, and person. The resident had no short or long-term memory deficits. The resident was capable of independent cognitive skills for daily decision making. The resident had no impairment in communication. The resident was on oxygen via nasal cannula at 3.5 liters per minute. The resident was documented as having had no abnormal behaviors. A Family/Resident Concern (grievance) form dated 4/24/18 for Resident #5 was reviewed. The form was completed by the facility Social Worker (SW). The form documented the resident made an allegation Nursing Assistant (NA) #1 grabbed the resident's face with both hands, shook her head, and told the resident to go to sleep on 4/23/18. The form documented the resident had stated she had rang her call bell because she had needed assistance. In addition the resident informed the SW it took a long time for NA #1 to answer her call light and when NA #1 did answer	F 600	Policy and that they agreed to abide by the policy at all times. All new staff will be trained on the facility Abuse Policy during Orientation and prior to being allowed to work on the floor with residents. As part of this training, each new hire will be required to take a written test to show their knowledge and understanding of the facility Abuse Policy. " Since Nurse Aide #1 was terminated, no monitoring of her interactions and behavior with residents is needed. However, the facility will monitor to ensure that all current staff are abiding by the facility Abuse Policy. This monitoring will be done in two parts. First, the facility Social Worker will conduct five (5) resident interviews a month for three (3) months then two (2) interviews a month for three (3) months to ask if any resident has experienced abuse of any kind from staff. Secondly, the facility Administrator will conduct five (5) staff interviews a month for three (3) months then two (2) interviews a month for three (3) months in which the staff members will be given a written test to ensure that staff are knowledgeable on the facility□s Abuse Policy. The results of these interviews will be recorded on a QA form and will be discussed each week in the weekly QA Meetings as well as the Monthly QA Meeting that is attended by the facility Medical Director. The facility Medical Director will be contacted for advice and guidance should the need for changes be identified prior to the Monthly QA meeting. " The facility Administrator, Cathy Almon, will be responsible for the	

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her call light, NA #1 was short with her and rude. The form further documented the resident stated NA #1 was rough with her while cleaning her after a bowel movement. The final documentation of the resident's concern or grievance was Resident #5 stated NA #1 makes her feel unsafe. The grievance form was investigated by the administrator and the corrective action listed on the form was NA #1 was terminated for abuse. The investigation was signed by the administrator on 4/30/18.

A 24 Hour Initial Report for an Allegation of abuse was faxed to the Health Care Personnel Registry on 4/24/18 from the facility. The alleged incident occurred on 4/23/18 at approximately 9:00 PM. The allegation description was Resident #5 reported NA #1 grabbed her on both sides of her face, shook her and told her to go to sleep after she had rang her call bell for assistance. The employee was documented as having been placed on suspension and was removed from the schedule pending the outcome of the investigation. The report was signed by the administrator and dated 4/24/18.

A nurses' note for Resident #5 dated 4/25/18 at 12:26 PM documented the resident was alert and oriented. The note further documented the resident was weepy about being at the facility. The nurse documented she spoke with the resident at the bed side multiple times. The nurse documented the resident stated that she had just wanted someone in the room with her all of the time. The nurse provided further documentation she checked on the resident several times during the shift.

A nurses' note for Resident #5 dated 4/30/18

implementation of this plan of correction.

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documented the resident was alert and oriented and had been feeling anxious during the shift.

A review of the 5-Working Day Report submitted by the facility for an allegation of abuse to the Health Care Personnel Registry on 5/1/18 was reviewed. The report documented on 4/23/18 at approximately 9:00 PM Resident #5 alleged NA #1 grabbed her face with both hands, shook her head, and told her to go to sleep. Resident #5 was documented as having been alert and oriented to time, place, and person. The allegation was documented as having been investigated and substantiated by the facility administrator. The investigation end date was 4/27/18. NA #1 was documented as having been terminated as a result of the investigation on 5/1/18. (Please note the employee was suspended as a result of the allegation on 4/24/18 per the 24 hour report submitted on 4/24/18.) The report was signed by the administrator on 5/1/18.

An interview was conducted with the administrator on 5/4/18 at 10:51 AM. The administrator stated she received the grievance with the allegation of abuse from Resident #5 regarding NA #1 the morning of 4/24/18 shortly after she arrived to the facility. The administrator stated she initiated an investigation immediately regarding abuse and suspended NA #1 also on the same date. The administrator stated the SW had interviewed other alert and oriented residents and NA #1 was identified as having been rough with them during care. The administrator stated as a result of the investigation the allegation of abuse in regards to NA #1 was terminated on 5/1/18. The administrator stated a 24 hour report and 5 day report were completed and faxed to the

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Health Care Personnel Registry regarding the allegation, suspension, investigation, substantiation, and termination. In addition the administrator stated the Health Care Personnel Registry had contacted the facility and had informed the administrator an onsite investigation would be completed by the Health Care Personnel Registry.

An interview was conducted with Resident #5 on 5/4/18 at 11:50 AM. The resident stated she reported on 4/24/18 NA #1 had put her hands on both sides of the resident's face, held her face, and told the resident forcefully to "go to sleep." The resident stated the NA scared her a little bit when she had done that. The resident stated she had been ringing her call light because she had had some confusion about where she was at. The resident stated she did not ring her call light after interaction with the NA. The resident stated it had happened in the evening of 4/23/18 but she could not remember an exact time. The resident further clarified the NA did not squeeze or shake her head but was not being gentle. The resident stated there was no one else in the room to witness the interaction. The resident further stated the NA had only acted in that manner one time and the NA had not acted like that in the past. The resident finally stated she had had no bad experiences with any of the other staff members at the facility.

A phone interview was conducted with NA #1 on 5/4/18 at 1:10 PM. The NA stated Resident #5 was sweating and she had felt both sides of her head with hands. The NA stated when she was feeling the resident's head the resident "jumped up" moving her head and shoulders up and made the statement, I know my blood sugar, I know it's

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high. NA #1 stated she did not tell the resident to go to sleep. The NA stated she had not done anything forceful with the resident. The NA stated the resident was behaving oddly. The NA stated the resident's hair was very sweaty and wet. The NA also stated she did not tell the resident to stop ringing her call light. The NA stated the resident continued to ring her call light through the evening.

An interview was conducted with the administrator on 5/4/18 at 2:15 PM. The administrator stated the social worker had conducted the interview with Resident #5 and conducted interviews with other alert and oriented residents regarding abuse. The administrator stated when she had informed NA #1 on 4/24/18 the NA stated she knew who had made an allegation without the administrator informing her. The administrator stated when she had interviewed the NA the NA stated she had not grabbed the resident's face but had attempted to check the resident for a fever by placing her hand on the resident's face. The administrator stated there was no physical injury to the resident. The administrator stated the SW conducted interviews with other alert and oriented residents regarding abuse. The administrator stated no other residents had made an allegation of abuse but four residents on NA #1's assigned hall had made statement that NA #1 was rough with them, spoke harshly to them, was rough with their roommate, or was spoke harshly to their roommate. The administrator further stated she substantiated the allegation of abuse for NA #1 from Resident #5 based on the allegation received from Resident #5 on 4/24/18, NA #1 pre-emptively identifying the victim, and the results from resident interviews which yielded statements from other residents in

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which they had identified NA #1 having been rough with them.

An interview was conducted with the Social Worker (SW) on 5/4/18 at 2:39 PM. The SW stated she had interviewed Resident #5 on 4/24/18 and the resident informed the SW she had rang her call light during the evening of 4/23/18 and when NA #1 answered her call light, NA #1 grabbed the resident's face with her hands and had told her to go to sleep. The SW stated the resident continued during the interview and told the SW NA #1 was in a hurry to get out of the room and was rude when she needed help. The SW stated the resident also stated NA #1 was rough with her when she had cleaned her. The SW stated the resident told her that was the only time the NA had grabbed her face. The SW stated she went back and interviewed the resident on 4/25/18 and the resident's story was consistent. The SW stated there was nothing wrong with Resident #5's mind, her mind was sharp.

On 5/4/18 the administrator provided an investigation timeline in regards to the allegation of abuse made by Resident #5 about NA #1. The conclusion of the timeline documented the determination of the investigation was NA #1 had abused Resident #5 on 4/23/18. The timeline further documented abusive behavior had been substantiated related to the allegation from Resident #5 regarding the incident on 4/23/18. The timeline documented NA #1 was terminated for abuse and had been report to the Healthcare Personnel Registry.

During an interview conducted on 5/4/18 at 4:36 PM the administrator stated it was her

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F 600	Continued From page 8 expectation that abuse should not occur.	F 600		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, manufacturer representative interview, surgeon interview and staff interviews, the facility failed to ensure proper application of a cervical collar (neck brace) for one of four resident reviewed for medical equipment (Resident #1). The findings included: Resident #1 was admitted to the facility 4/20/18 with diagnoses which included: Paranoid schizophrenia, diskitis (inflammation of the spinal discs) of the cervical region (neck), psychosis, and osteomyelitis (bone infection) of the cervical region (neck). A review of Resident #1's Minimum Data Set (MDS) revealed the most recent completed assessment was an admission assessment with an Assessment Reference Date (ARD) of 4/27/18. The MDS assessment indicated Resident #1 had no cognitive impairment. The resident was coded as having had rejected care	F 684	" The deficient practice is the failure to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident□s choices. This practice occurred due to staff not fully understanding the correct positioning of Resident #1□s c-collar due to a lack of clear communication from staff and the residents surgeon on the proper positioning of the collar as well as the resident□s non-compliance with allowing the collar to be adjusted into the proper position. Resident #1 self-adjusted the collar into improper position and did not always allow staff to readjust it back into proper position. In fact, Resident #1 was wearing the collar in an improper position when he arrived at the facility for admission. Staff were inserviced on the proper positioning and were adjusting the collar before the resident was taken to	5/5/18

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F 684	Continued From page 9 for 1-3 days during the seven day look back period of the assessment. The resident was coded as having had required extensive assistance of one person for bed mobility, transfer (such as from the bed to a chair), dressing, toilet use, and personal hygiene. The resident was coded as using tobacco during the assessment period. The resident was coded as having had a surgical wound. Review of Resident #1's baseline care plan, dated 4/24/18, revealed no documented information regarding the resident's neck brace, removal of the neck brace, length of time the neck brace was to be warn, or how the neck brace was to be properly applied. There was no care plan in which non-compliance was care planned with the exception of the resident had refused to wear a smoking apron on 5/2/18 A review of the medical record for Resident #1 revealed a therapy note dated 4/30/18 and timed 11:09 AM written by the Physical Therapy Assistant (PTA). The PTA documented the resident was attempting to get his medication without his neck brace donned (put on). The PTA documented he asked the resident where his brace was and why it was not on? The resident responded he had slept without the neck brace last night. An observation was made on 5/2/18 from 9:45 AM to 10:03 AM of Resident #1. The observation revealed the resident was sitting outside at the smoking area. The resident was sitting in his wheelchair. The resident was wearing a cervical collar or neck brace. The neck brace protruded forward from under the resident's chin forward and up for approximately 3-4 inches.	F 684	smoke and on any occasion that the resident would allow. As of May, 13, 2018, Resident #1 has removed the c-collar and refuses to wear it at all. Facility staff and the Medical Director have attempted and continue to attempt to educate the resident on the importance of wearing the c-collar but he has remained non-compliant and becomes extremely agitated when staff attempt to educate him. " Any resident may have the potential to be affected by this practice. All facility staff were inserviced on the proper placement of the c-collar and on the need to readjust the collar into the proper position on May 3, 2018. Facility staff adjusted the c-collar into the proper position prior to assisting the resident outside for supervised smoking and anytime that the resident would allow until May 13, 2018. As of May 13, 2018, Resident #1 has adamantly refused to wear the c-collar. The facility Medical Director and staff have attempted to educate the resident for the need to wear the c-collar but he continues to refuse and becomes highly agitated each time staff attempt to discuss it with him. The surgeon that performed the resident□s surgery has been notified of Resident#1□s non-compliance and has instructed the facility to document the non-compliance. All new hire employees will be inserviced and trained on the proper placement of Resident #1's c-collar as well as what to do if Resident #1 refuses to wear the c-collar during orientation and before taking an assignment on the floor.	

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F 684	Continued From page 10 During an interview conducted on 5/1/18 at 12:12 PM with Medication Aide (MA) #1 she stated the brace was ordered not to come off. The MA further stated the resident was non-compliant and had taken the brace off himself. An observation was conducted of Resident #1 on 5/2/18 at 12:42 PM. The resident was eating lunch in the dining room. The resident's neck brace was observed to be off of the resident. The Director of Nursing (DON) came and assisted the resident with the placement of his neck brace by placing the back half of the neck brace on the back of the resident's neck first. The DON was then observed to put the front half of the neck brace on the resident. Lastly the nurse fastened the Velcro straps to hold the front and rear halves of the neck brace together. The chin area support portion of the neck brace was observed to be protruding three to four inches in front of the resident mouth and chin in a bowl like manner. A phone interview was conducted with a company representative from the manufacturer of the neck brace on 5/2/18 at 3:03 PM. The representative stated the neck collar worn by Resident #1 was designed so the front part of the brace should be flush with the chin. The representative stated the front part should not stick out past the chin. The representative stated if the front part of brace was sticking out past the chin it may be due someone having applied the collar wrong, such as applying the back part of the collar first and then the front. The representative stated the front needed to be applied first so the brace can be fitted up under the chin, and does not protrude in front of the resident, then the back should be applied, then the Velcro straps should be secured. The	F 684	" Administrative staff (Cathy Almon, Sheila Coughenour, Cathy Perry, Angie Harrington, Kim Nichols, Sid McGuire, Debbie Marsh, Robin Jones, Laura Hedrick) have been doing QA inspections and monitoring of the placement of Resident #1□s c-collar during the designated smoking times of 7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm and 8:00pm since May 3, 2018 to ensure that the c-collar was positioned correctly. While Administrative staff continue to monitor the resident during these times and throughout the day, Resident #1 has chosen not to wear the c-collar anymore as of May 13, 2018. Although facility staff and the facility Medical Director have repeatedly attempted to council with and educate the resident on the need for the c-collar, he continues to be non-compliant. Administrative staff are documenting the visual inspections that they are doing on a QA form and are noting the resident□s non-compliance with wearing the c-collar. Documentation of the resident□s non-compliance is also being recorded in the resident□s medical record. The QA checks that the Administrative staff are doing are being discussed at the weekly QA meetings and with the Medical Director at the Monthly QA and as needed for guidance and advice. " The facility Administrator will be responsible for the implementation of this plan of correction.	

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representative lastly stated there were videos available on their company's web site on how to properly apply and wear the collar.

An interview conducted with the Speech Language Pathologist (SLP) was conducted on 5/2/18 at 4:20 PM. The SLP stated Resident #1 had refused to work with speech therapy. The SLP stated she believed the neck brace should be more under the resident's chin to keep his neck straighter. The SLP stated she did not believe the neck brace was on the resident's neck properly.

A review conducted of the Electronic Medical Record conducted on 5/2/18 at 4:25 PM of Resident #1 and the resident Medical Record of Resident #1 located on the unit revealed no admission orders regarding the application, removal, care, or directives regarding the neck brace for Resident #1.

A review completed of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) conducted on 5/2/18 at 4:28 PM for Resident #1 revealed no entries in regards to the application, removal, care, or directives regarding the neck brace for Resident #1.

An interview was conducted with Nurse #1 and the DON on 5/2/18 at 4:30 PM. Nurse #1 and the DON stated they were unable to discover any mention or orders regarding the neck brace for Resident #1.

A phone interview was conducted on 5/2/18 at 4:43 PM with the neurosurgeon who had performed Resident #1's neck surgery. He stated

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it was his expectation for the neck brace to be properly placed on the resident. He stated proper placement of the brace would include applying the front part of the brace first under the resident's chin so as to hold the chin in place. He stated if the front part of the brace was sticking up in front of the resident's chin and mouth, the brace was not properly applied. The surgeon further stated it was his expectation for the resident to continue to wear the brace until he returned for his follow up appointment. The surgeon clarified the brace could be removed for example if the resident were to be upright in a shower chair and was being supervised. He stated it was acceptable for the brace to be removed to allow the resident to eat but only if he was supervised and as soon as he was finished eating, the brace must be reapplied.

An interview and record review conducted with the DON on 5/2/18 at 5:12 PM revealed information on page 30 of the 153 page discharge summary for Resident #1 from the hospital pertaining to the neck brace, dated 4/19/18. The information on page 30 documented the resident was to wear the neck brace until he saw his appointment with the neurosurgeon on 5/22/18 at 2:30 PM. Further review of the page revealed documentation the resident was likely to wear the collar for 8 weeks total and at the time of the Discharge Summary the resident had only worn the neck brace for 2 weeks. The DON stated it was her expectation there should have been an order for the neck brace and the nurse who completed the admission orders should have contacted the resident's doctor or the surgeon for orders for the neck brace. The DON further stated the therapy department had not provided education regarding the neck brace to the staff

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F 684	Continued From page 13 and the facility had received no information regarding the neck brace from the hospital when the resident was admitted. An interview was conducted with the PTA on 5/3/18 at 10:10 AM. The PTA stated he had been working with Resident #1 and was discharging him due to his non-compliance. The PTA stated the neck brace was under the resident's chin when he had been initially evaluated in therapy. The PTA stated as the resident's stay lengthened, the front part of the brace at his chin, had extended more and more forward. The PTA stated the resident was very non-compliant with his brace. The PTA stated one morning when he went to get the resident for therapy the resident was not wearing his neck brace. The PTA stated he had found the resident's neck brace at the nurses' station. The PTA stated he was informed the resident had taken off the brace at night and slept without the brace in place. The PTA stated he had no orders nor had he received information about the brace when the resident was admitted. The PTA stated he had provided no information or education to anyone in the nurses' department about how to apply or remove the neck brace. Multiple attempts were made to interview Resident #1 throughout the investigation. Responses to questions were nonsensical or the resident refused to be interviewed. During an interview conducted on 5/4/18 at 4:36 PM the administrator stated it was her expectation for staff to be fully versed on how to properly use resident medical equipment.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/5/18

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F 689	Continued From page 14 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure safe smoking to prevent a resident from burning his cervical collar (neck brace) for one of four residents reviewed for safe smoking (Resident #1). Resident #1 had portions of his neck brace burned while smoking with and without supervision while at the facility. Immediate jeopardy began on 4/23/18 when resident #1 was documented in a nurses' note as having had burned a few holes in his neck brace. The immediate jeopardy was removed on 5/4/18 at 8:48 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: Resident #1 was admitted to the facility 4/20/18 with diagnoses which included: Paranoid schizophrenia, diskitis (inflammation of the spinal	F 689	" The deficient practice is the failure to provide supervision to prevent accidents and injuries to the resident. This practice occurred due to staff not fully understanding the proper positioning of the resident□s c-collar, the need for the smoking apron, and the need to ensure that they were assisting the resident by ashing his cigarettes to ensure that no hot ashes were falling between the c-collar and the resident□s neck. Staff did not fully understand due to a lack of clear communication from staff members on the proper positioning of the c-collar, the need for the smoking apron, and the need to ash the resident□s cigarettes for him. " The supervised smoking plan for this resident is he is to wear a smoking apron and staff are to ensure that the c-collar is positioned correctly so that the tip of the cigarette does not touch the c-collar. Additionally, staff will be required to remove the cigarette from the resident□s mouth and to ash the cigarette to ensure that no ashes are falling into the space between the resident□s face and the c-collar. On May 3, 2018, Physical Therapy inserviced all staff on the proper	

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F 689	Continued From page 15 discs) of the cervical region (neck), psychosis, and osteomyelitis (bone infection) of the cervical region (neck). A review of Resident #1's Minimum Data Set (MDS) revealed the most recent completed assessment was an admission assessment with an Assessment Reference Date (ARD) of 4/27/18. The MDS assessment indicated Resident #1 had no cognitive impairment. The resident was coded as having had rejected care for 1-3 days during the seven day look back period of the assessment. The resident was coded as having had required extensive assistance of one person for bed mobility, transfer (such as from the bed to a chair), dressing, toilet use, and personal hygiene. The resident was coded as using tobacco during the assessment period. The resident was coded as having had a surgical wound. A review of the facility supplied list of smoking residents provided on 5/2/18 revealed Resident #1 was listed as a supervised smoker. A review of the Safe Smoking Evaluation for Resident #1 dated 4/23/18 revealed the Interdisciplinary Team's determination was the resident was an unsafe smoker and needed supervision. The evaluation stated to see the resident's care plan for further details. The Safe Smoking Evaluation for Resident #1 was completed by Nurse #2. Review of Resident #1's baseline care plan, dated 4/24/18, revealed an update on the same day which documented the resident was a supervised smoker and was to wear an apron. There was an additional update dated 4/22/18	F 689	fit of the resident□s c-collar so that staff are aware of when it needs to be adjusted before the resident goes out to smoke. Also, the resident□s current care plan will be reviewed with all staff and each staff member will sign off on the care plan to state understanding of the resident□s smoking status, the need for the smoking apron, and that they will need to ash the resident□s cigarette for him to ensure that no ashes fall in between the resident□s neck and the c-collar. As of May 13, 2018, the smoking plan for this resident has been modified due to Resident#1□'s non-compliance with wearing the c-collar and his ability to ash his own cigarettes safely when he is not wearing the collar. The current plan is that he remains a supervised smoker and must wear a smoking apron while smoking. Staff continue to attempt to get Resident #1 to wear his c-collar, but he adamantly refuses to do so. Since Resident #1 has demonstrated the ability to safely smoke and ash his own cigarettes without the c-collar in place, staff are now monitoring him for compliance with the ashing aspect, wearing of the smoking apron, and safety. All new hire employees will be trained and inserviced on the current supervised smoking plan for Resident #1 and will have the resident's care plan reviewed with them during orientation to ensure that they are aware of the Resident's smoking status and need for the smoking apron and supervision/monitoring prior to being put to work on the floor. " As a supervised smoker, the resident	

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which documented the resident was refusing to wear the smoking apron. There were no additional approaches or interventions listed due to the resident's refusal to wear the smoking apron.

A review of the medical record for Resident #1 revealed a nurses' note written by the Director of Nursing (DON), dated 4/24/18, which read in part: Late entry for 4/23/18. Resident had been evaluated for safe smoking and was a supervised smoker. The resident was documented as having been smoking other residents' cigarettes. The resident was educated on supervised smoking and being noncompliant with his need for supervision. The resident was documented as having had actually burned a few holes in his neck brace which was in place.

A nurses' note dated 4/24/18 at 7:28 PM written by the Director of Nurses (DON) documented Resident #1 had a fall in the facility hallway. The resident had been documented as having had fallen when he was attempting to pick up a pack of cigarettes off of the floor he had dropped. The resident was informed he was unable to keep cigarettes on his person due to having been assessed to have been an unsafe smoker.

A nurses' note dated 4/25/18 at 6:52 PM written by the DON documented Resident #1 continued to independently go outside and obtain cigarettes from other residents and the resident was a supervised smoker. The intervention put into place was a wandering transmitter was placed on the resident to alert staff for the need for supervision when the resident exited the door which lead to the resident smoking area.

will only be smoking at designated times (7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm, 8:00pm). In order to monitor the plan of correction and to ensure that the resident□s c-collar and smoking apron are in place, Administrative Staff (Cathy Almon, Sheila Coughenour, Cathy Perry, Angie Harrington, Kim Nichols, Sid Maguire, Debbie Marsh, Robin Jones, Laura Hedrick) will do visual inspections during these designated times to make sure that the apron and c-collar are properly in place and that staff are assisting the resident by ashing the cigarette for him. While Administrative staff continue to monitor the resident during these times and throughout the day, Resident #1 has chosen not to wear the c-collar anymore as of May 13, 2018. Although facility staff and the facility Medical Director have repeatedly attempted to council with and educate the resident on the need for the c-collar, he continues to be non-compliant. Administrative staff are documenting the visual inspections that they are doing on a QA form and are noting the resident□s non-compliance with wearing the c-collar. Documentation of the resident□s non-compliance is also being recorded in the resident□s medical record. The QA checks that the Administrative staff are doing are being discussed at the weekly QA meetings and with the Medical Director at the Monthly QA and as needed for guidance and advice.

" The Administrator will be responsible

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An interview was conducted with the DON on 5/2/18 at 12:31 PM. The DON stated she was contacted on the weekend, Sunday, 4/22/18, by Nurse #2 and was informed Resident #1 was receiving cigarettes from other residents and smoking other resident's cigarettes. The DON stated she told the nurse who was at the facility to complete a smoking assessment on the resident.

Nurse #2 was unavailable for interview at the time of the investigation due to being on Medical Leave.

A continuous observation was made on 5/2/18 from 9:45 AM to 10:03 AM of Resident #1. The observation revealed the resident was sitting outside at the smoking area. The resident was sitting in his wheelchair. The resident was wearing a cervical collar or neck brace. The neck brace protruded forward from under the resident's chin forward and up for approximately 3-4 inches. To the left of the resident's mouth there was a semi-circular portion of the neck brace foam missing which was approximately golf ball sized. In addition to the area on the left, there were two smaller areas, approximately pea sized missing to the right of the resident's mouth on the neck brace. At 9:57 AM the lit portion of the cigarette was observed to be setting and making contact with the foam of the neck brace as the resident held the other end of the cigarette in his mouth. The resident would periodically point the cigarette up with his mouth, but inevitably the lit end of the cigarette would return to rest upon the portion of the neck brace where the foam was missing to the left of the resident's mouth. The resident was observed to not be wearing a smoking apron. Through the whole observation period, the only time the resident removed the cigarette from his

for implementing this plan of correction.

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mouth was when he disposed of the cigarettes in the ash tray. The resident was not observed ashing the cigarette with his hands. The resident moved the cigarette up and down using his mouth and lips. The Maintenance Director (MD) was present during the observation. The MD was observed supervising the resident through the whole observation. The MD gave the resident a second cigarette and lit it for him during the observation. The MD was not observed to have placed a smoking apron on the resident. The MD was not observed assisting the resident to ash his cigarette. The MD did not intervene when the lit portion of the cigarette came into contact with the foam of the neck brace.

An interview was conducted with the MD on 5/02/18 at 9:54 AM while he was supervising Resident #1 smoking. The MD stated he was outside supervising Resident #1. The MD stated Resident #1 was a sometimes supervised smoker and sometimes Resident #1 could come out on his own to smoke independently.

An interview was conducted with Medication Aide (MA) #1 on 5/2/18 at 11:57 AM. MA #1 stated Resident #1 was a supervised smoker and due to being a supervised smoker the resident was not allowed to keep his cigarettes or a lighter. The MA stated staff members light the resident's cigarettes, the resident did not light his own cigarettes. The MA stated the resident did not and refused to use his hands to ash the cigarette. The MA stated the resident moved the cigarette up and down using his lips and the cigarette would bump the collar sometimes. The MA stated the resident refused to wear a smoking apron. The MA stated she did not recall seeing burn marks on the collar when the resident

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arrived from the hospital.

An interview conducted with the DON on 5/2/18 at 12:05 PM revealed Resident #1 was initially not believed to be a smoker at the time of his admission. The DON stated the resident started to go outside to the smoking area and getting cigarettes from another resident. The DON stated she had encouraged the resident to be a safe smoker. She further stated the resident had been observed "thumping" the lit cigarette end of the cigarette on the foam part of his neck brace. The DON stated the way the lit end of the cigarette was resting on his neck brace she could see the burned area was getting bigger on his neck brace. The DON stated there was only a one little burn mark on Resident #1's neck collar when he was first admitted to the facility.

During an interview conducted on 5/2/18 at 12:12 PM, MA #1 stated the resident was receiving cigarettes from other residents and was not being supervised when he was smoking when he first arrived at the facility. The MA stated the resident did not have any cigarettes in his possession when he first arrived to the facility. The MA stated she believed most of the area which was burned away from the neck brace occurred when the resident had not been supervised and was receiving cigarettes from other residents.

An interview was conducted with Nurse #1 on 5/2/18 at 12:20 PM. The nurse stated Resident #1 had gone out to the smoking area and set his neck collar on fire with a lit cigarette while she was supervising him. The nurse stated the resident refused to wear the smoking apron. The nurse stated the resident went outside to smoke about once per hour. The nurse stated the

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resident did not use his hands to smoke. The nurse stated when the resident would sit and smoke the lit end of the cigarette would come into contact with the neck brace and that has caused foam areas of the neck brace to burn away. The nurse stated when the resident first arrived to the facility there were no burned areas on the neck brace. The nurse stated the resident ashed his cigarette by moving his mouth and moving his head. The nurse further stated she had been supervising the resident when he was smoking on one occasion and the lit end of the cigarette had come into contact with the foam on the neck brace. The nurse stated on that occasion the foam on the neck brace had started to smolder, there were not flames, however the areas started to burn, turn red, and was smoking. The nurse stated she had to reach over and put it out with her fingers and that was one of the times in which parts of the brace were burned away.

An observation was conducted of Resident #1 on 5/2/18 at 12:42 PM. The resident was eating lunch in the dining room. The resident's neck brace was observed to be off of the resident. The burned areas of the neck brace were much more visible when the neck brace was not on the resident.

A phone interview was conducted with a company representative from the manufacturer of the neck brace on 5/2/18 at 3:03 PM. The representative stated the neck collar worn by Resident #1 was not made from a fire resistant type of material.

Multiple attempts were made to interview Resident #1 throughout the investigation. Responses to questions were nonsensical or the resident refused to be interviewed.

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During an interview conducted on 5/4/18 at 4:36 PM the administrator stated it was her expectation for residents who smoke to smoke safely.

The Administrator was informed of Immediate Jeopardy on 5/2/18 at 6:40 PM.

On 5/4/18 at 8:48 AM, the facility provided the following Credible Allegation of Immediate Jeopardy Removal:

ALLEGATION OF IMMEDIATE JEOPARDY REMOVAL

F-689

The deficient practice is the failure to provide supervision to prevent accidents and injuries to the resident. This practice occurred due to staff not fully understanding the proper positioning of the resident's c-collar, the need for the smoking apron, and the need to ensure that they were assisting the resident by ashing his cigarettes to ensure that no hot ashes were falling between the c-collar and the resident's neck. Staff did not fully understand due to a lack of clear communication from staff members on the proper positioning of the c-collar, the need for the smoking apron, and the need to ash the resident's cigarettes for him.

The supervised smoking plan for this resident is he is to wear a smoking apron and staff are to ensure that the c-collar is positioned correctly so that the tip of the cigarette does not touch the c-collar. Additionally, staff will be required to remove the cigarette from the resident's mouth and to ash the cigarette to ensure that no ashes are falling into the space between the resident's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

face and the c-collar. On May 3, 2018, Physical Therapy will in-service all staff on the proper fit of the resident's c-collar so that staff are aware of when it needs to be adjusted before the resident goes out to smoke. Also, the resident's current care plan will be reviewed with all staff and each staff member will sign off on the care plan to state understanding of the resident's smoking status, the need for the smoking apron, and that they will need to ash the resident's cigarette for him to ensure that no ashes fall in between the resident's neck and the c-collar.

As a supervised smoker, the resident will only be smoking at designated times (7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm, 8:00pm). In order to monitor the plan of correction and to ensure that the resident's c-collar and smoking apron are in place, Administrative Staff do visual inspections during these designated times to make sure that the apron and c-collar are properly in place and that staff are assisting the resident by ashing the cigarette for him.

The Administrator will be responsible for implementing this plan of correction.

The credible allegation was verified on 5/4/18 at 5:00 PM as evidenced by staff interviews and an observation of Resident #1 smoking, wearing a smoking apron, and staff ashing the cigarette of the resident as needed. The lit end of the cigarette was not observed to come into contact with the resident's neck collar and the collar was covered with the smoking apron. Staff education was initiated on 5/3/18 regarding the supervised smoking plan for Resident #1 to wear a smoking apron and staff are to ensure that the c-collar is positioned correctly so that the tip of the cigarette does not touch the c-collar. Additionally, staff will be required to remove the cigarette from the

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F 689	Continued From page 23 resident's mouth and to ash the cigarette to ensure that no ashes are falling into the space between the resident's face and the c-collar. All staff interviewed (nursing and non-nursing staff, administrative staff) stated Resident #1 was to be supervised whenever he smoked, he was to wear a smoking apron, the lit portion of the cigarette was not to come into contact with the neck brace, and they were to ash the cigarette for the resident. Verification of education for staff regarding the education regarding wandering residents was completed on 5/4/18.	F 689		
F 835 SS=J	Administration CFR(s): 483.70 §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 review and staff interviews, the administration failed to provide oversight and leadership to facility staff to maintain a safe environment and ensure safe and supervised smoking for one of four residents reviewed for safe smoking (Resident #1). Resident #1 had portions of his neck brace burned while smoking with and without supervision while at the facility. Immediate jeopardy began on 4/23/18 when resident #1 was documented in a nurses' note as having had burned a few holes in his neck brace. The immediate jeopardy was removed on 5/4/18 at 8:48 AM when the facility provided an	F 835	" This deficiency was cited due a lack of full and proper communication from Administration to the floor staff. Staff were not correctly following the facility policy for supervised smokers and were therefore not ensuring that the resident□s c-collar was positioned correctly, that the smoking apron was in place each time, or ashing the resident□s cigarette to prevent ashes from falling between the c-collar and the resident□s neck. " A review of this incident shows that there was a failure to properly inservice staff to policy and procedure as it applies to this specific resident□s safety needs.	5/5/18

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F 835	Continued From page 24 acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: Cross Refer to F689: Based on observations, record review and staff interviews, the facility failed to ensure safe smoking to prevent a resident from burning his cervical collar (neck brace) for one of four resident reviewed for safe smoking (Resident #1). Resident #1 had portions of his neck brace burned while smoking with and without supervision while at the facility. During an interview conducted on 5/4/18 at 4:36 PM the administrator stated it was her expectation for safe smoking recommendations to be communicated effectively to front line staff. The Administrator was informed of Immediate Jeopardy on 5/2/18 at 6:40 PM. On 5/4/18 at 8:48 AM, the facility provided the following Credible Allegation of Immediate Jeopardy Removal: ALLEGATION OF IMMEDIATE JEOPARDY REMOVAL F-835 This deficiency was cited due a lack of full	F 835	On May 3, 2018, facility staff were inserviced on the proper placement of the c-collar, the resident□s specific safety needs of the smoking apron and ashing of the cigarette. As of May 13, 2018, the smoking plan for this resident has been modified due to Resident#1□s non-compliance with wearing the c-collar and his ability to ash his own cigarettes safely when he is not wearing the collar. The current plan is that he remains a supervised smoker and must wear a smoking apron while smoking. Staff continue to attempt to get Resident #1 to wear his c-collar, but he adamantly refuses to do so. Since Resident #1 has demonstrated the ability to safely smoke and ash his own cigarettes without the c-collar in place, staff are now monitoring him for compliance with the ashing aspect, wearing of the smoking apron, and safety. All new hire employees will be trained and inserviced on the current supervised smoking plan for Resident #1 and will have the resident's care plan reviewed with them during orientation to ensure that they are aware of the resident's smoking status and need for the smoking apron and supervision/monitoring prior to being put to work on the floor. " As a supervised smoker, the resident will only be smoking at designated times (7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm, 8:00pm). In order to monitor the plan of correction and to ensure that the resident□s c-collar and smoking apron are in place, Administrative Staff (Cathy Almon, Sheila	

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F 835	Continued From page 25 and proper communication from Administration to the floor staff. Staff were not correctly following the facility policy for supervised smokers and were therefore not ensuring that the resident's c-collar was positioned correctly, that the smoking apron was in place each time, or ashing the resident's cigarette to prevent ashes from falling between the c-collar and the resident's neck. A review of this incident shows that there was a failure to properly inservice staff to policy and procedure as it applies to this specific resident's safety needs. On May 3, 2018, facility staff were inserviced on the proper placement of the c-collar, the resident's specific safety needs of the smoking apron and ashing of the cigarette As a supervised smoker, the resident will only be smoking at designated times (7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm, 8:00pm). In order to monitor the plan of correction and to ensure that the resident's c-collar and smoking apron are in place, Administrative Staff (Cathy Almon, Sheila Coughenour, Cathy Perry, Angie Harrington, Kim Nichols, Sid Maguire, Debbie Marsh, Robin Jones, Laura Hedrick) will do visual inspections during these designated times to make sure that the apron and c-collar are properly in place and that staff are assisting the resident by ashing the cigarette for him. The facility Administrator will be responsible for implementing this plan of correction. The credible allegation was verified on 5/4/18 at 5:00 PM as evidenced by staff interviews and an observation of Resident #1 smoking, wearing a smoking apron, and staff ashing the cigarette of the resident as needed. The lit end of the cigarette was not observed to come into contact with the resident's neck collar and the collar was covered with the smoking apron. Staff education	F 835	Coughenour, Cathy Perry, Angie Harrington, Kim Nichols, Sid Maguire, Debbie Marsh, Robin Jones, Laura Hedrick) will do visual inspections during these designated times to make sure that the apron and c-collar are properly in place and that staff are assisting the resident by ashing the cigarette for him. While Administrative staff continue to monitor the resident during these times and throughout the day, Resident #1 has chosen not to wear the c-collar anymore as of May 13, 2018. Although facility staff and the facility Medical Director have repeatedly attempted to council with and educate the resident on the need for the c-collar, he continues to be non-compliant. Administrative staff are documenting the visual inspections that they are doing on a QA form and are noting the resident□s non-compliance with wearing the c-collar. Documentation of the resident□s non-compliance is also being recorded in the resident□s medical record. The QA checks that the Administrative staff are doing are being discussed at the weekly QA meetings and with the Medical Director at the Monthly QA and as needed for guidance and advice. " The facility Administrator will be responsible for implementing this plan of correction.	

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F 835	Continued From page 26 was initiated on 5/3/18 regarding the supervised smoking plan for Resident #1 to wear a smoking apron and staff are to ensure that the c-collar is positioned correctly so that the tip of the cigarette does not touch the c-collar. Additionally, staff will be required to remove the cigarette from the resident's mouth and to ash the cigarette to ensure that no ashes are falling into the space between the resident's face and the c-collar. All staff interviewed (nursing and non-nursing staff, administrative staff) stated Resident #1 was to be supervised whenever he smoked, he was to wear a smoking apron, the lit portion of the cigarette was not to come into contact with the neck brace, and they were to ash the cigarette for the resident. Verification of education for staff regarding the education regarding wandering residents was completed on 5/4/18.	F 835		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		5/5/18

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F 865	Continued From page 27 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 7/13/17 recertification survey. This was for one deficiency in the area of: Free of Accident Hazards/supervision/devices. The deficiency was recited again on a current complaint investigation on 5/4/18. The continued failure of the facility during multiple federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 483.25- Based on observation, interviews with staff and residents and record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in fourteen (14) of sixteen (16) resident's bathrooms (101, 104, 103/105, 106/108, 107/109, 201/203, 202/204,205, 206,218, 301/303, 302/304, 305/307 and 306/308) and in one of two shower rooms (West). From the 7/13/17 recertification survey. During the complaint investigation of 5/4/18 the facility was cited for 483.25-failing to ensure safe smoking to prevent a resident from burning his cervical collar (neck brace) for one of four residents reviewed for safe smoking (Resident #1). Resident #1 had portions of his neck brace burned while smoking with and without	F 865	" The deficient practice is the failure to maintain implemented procedures and monitor the interventions that the committee put into place following the 7/13/17 recertification survey. The citation from 7/13/17 was for water temperatures and this citation is for failing to ensure safe smoking. The implemented procedures for the 7/13/17 survey have been maintained and monitored and have been effective. However, since both areas do fall under the regulation for Accident Hazards/Supervision/Devices, the citation at F-865 will be addressed as follows: The deficient practice is the failure to provide supervision to prevent accidents and injuries to the resident. This practice occurred due to staff not fully understanding the proper positioning of the resident□s c-collar, the need for the smoking apron, and the need to ensure that they were assisting the resident by ashing his cigarettes to ensure that no hot ashes were falling between the c-collar and the resident□s neck. Staff did not fully understand due to a lack of clear communication from staff members on the proper positioning of the c-collar, the need for the smoking apron, and the need to ash the resident□s cigarettes for him. " Any resident may be affected by this practice. The supervised smoking plan for this resident is he is to wear a smoking apron and staff are to ensure that the c-collar is positioned correctly so that the tip of the cigarette does not touch the	

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F 865	Continued From page 28 supervision while at the facility. An interview was conducted with the administrator on 5/4/18 at 4:36 PM. The administrator stated the facility had a Quality Assurance (QA) Committee. The administrator stated she had started at the facility on 4/11/18 and had not participated in a QA Committee meeting yet at the facility. The administrator stated her expectation was for the QA monitoring mechanisms to be continued until and identified deficient practice was completely resolved. The administrator further stated all deficient practices identified through the survey process would be reviewed in the upcoming QA Committee meeting.	F 865	c-collar. Additionally, staff will be required to remove the cigarette from the resident□s mouth and to ash the cigarette to ensure that no ashes are falling into the space between the resident□s face and the c-collar. On May 3, 2018, Physical Therapy inserviced all staff on the proper fit of the resident□s c-collar so that staff are aware of when it needs to be adjusted for proper fitting. Also, the resident□s current care plan will be reviewed with all staff and each staff member will sign off on the care plan to state understanding of the resident□s smoking status, the need for the smoking apron, and that they will need to ash the resident□s cigarette for him to ensure that no ashes fall in between the resident□s neck and the c-collar. As of May 13, 2018, the smoking plan for this resident has been modified due to Resident#1□s non-compliance with wearing the c-collar and his ability to ash his own cigarettes safely when he is not wearing the collar. The current plan is that he remains a supervised smoker and must wear a smoking apron while smoking. Staff continue to attempt to get Resident #1 to wear his c-collar, but he adamantly refuses to do so. Since Resident #1 has demonstrated the ability to safely smoke and ash his own cigarettes without the c-collar in place, staff are now monitoring him for compliance with the ashing aspect, wearing of the smoking apron, and safety. All new hire employees will be trained and inserviced on the current supervised smoking plan for Resident #1 and will have the resident's care plan reviewed	

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F 865	Continued From page 29	F 865		

with them during orientation to ensure that they are aware of the resident's need for the smoking apron and supervision/monitoring prior to being put to work on the floor.

" As a supervised smoker, the resident will only be smoking at designated times (7:00am, 9:30am, 11:00am, 1:30pm, 4:00pm, 6:00pm, 8:00pm). In order to monitor the plan of correction and to ensure that the resident□s c-collar and smoking apron are in place, Administrative Staff (Cathy Almon, Sheila Coughenour, Cathy Perry, Angie Harrington, Kim Nichols, Sid Maguire, Debbie Marsh, Robin Jones, Laura Hedrick) will do visual inspections during these designated times to make sure that the apron and c-collar are properly in place and that staff are assisting the resident by ashing the cigarette for him. While Administrative staff continue to monitor the resident during these times and throughout the day, Resident #1 has chosen not to wear the c-collar anymore as of May 13, 2018. Although facility staff and the facility Medical Director have repeatedly attempted to council with and educate the resident on the need for the c-collar, he continues to be non-compliant. Administrative staff are documenting the visual inspections that they are doing on a QA form and are noting the resident□s non-compliance with wearing the c-collar. Documentation of the resident□s non-compliance is also being recorded in the resident□s medical record. The QA checks that the Administrative staff are doing are being

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F 865	Continued From page 30	F 865	discussed at the weekly QA meetings and with the Medical Director at the Monthly QA and as needed for guidance and advice. " The Administrator will be responsible for implementing this plan of correction.	