STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 10/18/2018

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PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/15/18 through 10/18/18. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to place a call bell within reach during 3 observations for two days for 1 of 26 residents reviewed for accommodation of needs (Resident #37). Findings included: Resident #37 was admitted to the facility on 7/15/11 with diagnoses that included stroke with weakness and paralysis to the left side of her body.	F 558	Piney Grove Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement	11/8/18

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

Electronically Signed | 11/21/2018

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F 558	Continued From page 1 The Minimum Data Set (MDS) quarterly assessment dated 9/4/18 revealed the resident was cognitively intact, required extensive assistance of one staff member with bed mobility, transfers, dressing, toileting, personal hygiene and one-person total assistance for bathing. Resident #37 had impairment to her upper and lower extremities to one side of her body, used a wheelchair, and was always incontinent of bladder and bowel. A review of the Care Area Assessment dated 3/14/18 revealed Resident #37 triggered for Activities of Daily Living (ADLs). Resident #37's active care plan revealed a plan of care for ADL care with an intervention to include to keep call bell within reach. An observation and interview with Resident #37 on 10/15/18 at 12:16 PM, revealed the resident's call bell was wrapped around the left arm rest of her wheelchair. Resident #37 demonstrated that she was unable to reach across her body with her right arm to push the call bell. The resident reported that she cannot use her left arm after her stroke to reach the call bell, and that she had to wait for a staff member to come into her room if she needed any help when staff secured her call bell to her wheelchair like that. She stated she had informed several staff members of the problem but that it had happened several times. An observation of Resident #37 on 10/15/18 at 12:45 PM, revealed the resident's call bell was again wrapped around the left arm rest of her wheelchair. The resident was observed reaching over to use the call light but was unable to push the button. This surveyor alerted the resident's nursing assistant (NA) #3 that she was requesting assistance. He confirmed that the resident was unable to use her left arm since her stroke and	F 558	with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F558 The plan of correcting the specific deficiency The position of Piney Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency of failure to accommodate the need of resident #37- was failure to follow established policy due to knowledge deficit as a result of failure to maintain education and training of call bell placement. On 10/18/2018 the call light resident #37 was taken from the left side and placed on the right side where resident could reach and use it. On 10/31/18 resident # 37 was observed with call light in reach on right side of wheelchair Registered Nurse (RN) Resident # 37 has use of right arm and is able to use call light. The procedure for implementing the	

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F 558	Continued From page 2 required assistance with ADLs. An interview with Nurse #4 on 10/15/18 at 10:12 AM she reported the resident needed her call bell within reach in order to let her needs known to the staff and that she was able to use the call bell for assistance if within reach. An observation of Resident #37 on 10/16/18 at 10:32 AM revealed the resident's call bell wrapped around the left arm rest of her wheelchair. An interview was conducted with the Administrator on 10/18/18 at 4:45 pm and she reported it was her expectation that call bells should be within reach at all times.	F 558	acceptable plan of correction for the specific deficiency cited On 10/28/18, 10/29/18, and 10/30/18 the facility consultant, and/or licensed nurse audited all resident rooms to ensure call lights were in reach and able to be used by the resident. This audit included placement based on resident□s ability, hemiparesis. No other negative findings were noted. All nursing staff, including agency, will be in-serviced by 11/9/18 by the director of nursing (DON), staff facilitator, assistant director of nursing (ADON) and/or registered nurse (RN) on placing call lights within reach of resident, and on appropriate side based on resident ability. No nursing staff will be allowed to work after 11/9/18 until in-service completed. This in-service was added to the orientation process for all new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 11/9/18 an audit will be completed on 5 rooms daily 5x week x 12 weeks (to include all shifts, days, and random halls/room) by the DON, ADON, administrator, social worker, admission coordinator, minimum data set nurse/coordinator, and/or RN to ensure the resident is able to reach their call light using the Administrative Staff/Department	

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F 558	Continued From page 3	F 558	Head Rounds Sheet. The monthly quality improvement (QI) committee will review the results of the Administrative Staff/Department Head Rounds Sheet for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance performance improvement (QAPI) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 review, resident interview and staff interviews the facility failed to provide personal hygiene care including showers	F 677	The position of Piney Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure	11/8/18

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F 677	Continued From page 4 (Resident #8 & Resident #37), shaving, and nail care (Resident #8, and Resident #63) for 3 of 12 dependent residents reviewed for activities of daily living (ADLs). 1. Resident #8 was admitted to the facility on 1/19/18 with diagnoses that included chronic obstructive pulmonary disease, chronic kidney disease, dementia without behavioral disturbance, cognitive communication deficit, weakness and stroke. Review of the quarterly Minimum Data Set (MDS) dated 7/17/18 indicated Resident #8 had severe cognitive impairment with long and short- term memory problems. The MDS indicated extensive assistance of one staff person was required for bed mobility and transfer. He was totally dependent on staff for dressing, toileting and bathing. The MDS had no behaviors or rejection of care that had occurred. Review of the care plan dated 7/24/18 included a problem of total dependence on staff for activities of daily living. The interventions included hygiene, grooming, bathing, shaving and incontinence care was to be provided by staff. Review of the facility shower schedule revealed Resident #8 would receive showers by the day shift staff on Tuesdays and Thursdays. Interview on 10/15/18 at 3:41 pm with a family member revealed the resident was not shaved, his fingernails were long and dirty underneath on both hands. During the interview the family member explained she had asked staff to shave him, and there were three aides that would shave him. Further interview revealed the family	F 677	to provide showers, shaving and nail care for dependent resident was staff failure to follow established protocol related to activities of daily living (ADL)care related to knowledge deficit as a result of failure to train and reinforce training. On 10/22/2018 resident #8 was shaved by facility certified nursing assistant (CNA). On 10/22/2018 resident #8 was provided with nail care by facility CNA. On 10/28/2018 resident # 8 was observed by the facility nurse consultant with no facial hair noted, and nails without debris and without sharp edges. On 10/20/2018 resident #37 was provided a shower by facility CNA. On 10/28/2018 facility consultant visualized resident #37 with non-greasy appearance of hair. On 10/18/2018 resident #63 was provided a shower by facility CNA. On 10/18/2018 resident #63 was shaved by facility CNA. On 10/28/2018 resident #63 was observed by facility consultant to be without facial hair, with clean shirt and pants, with clean face and hands. Beginning 10/24/2018 the assistant director of nursing (ADON) began a shower preference audit with all residents and/or their responsible parties. This audit was completed on 10/31/2018. On 10/31/2018 facility consultant completed a shower audit for the past 7 days. Residents not provided showers were provided full bed baths by facility	

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F 677	Continued From page 5 member had an outside person come in to trim and clean his fingernails. The family member explained it had been about a month and a half since Resident #8 had his beard "cut" by family. She explained Resident #8 ' s former routine was to be "always clean shaven." On one occasion she had cut his beard, shaved him, and he informed her "it felt good." Observations on 10/15/18 at 11:00 am, 10/16/18 at 2:00 pm, and 10/17/18 at 1:50 pm revealed Resident #8 had a long growth of beard that not been shaved and his fingernails had a black substance underneath his nails on both hands. Review of a nurse ' s note dated 10/16/18 (Tuesday) revealed Resident #8 was "compliant with all care given." There were no refusals of showers or personal hygiene documented on this date. Interview on 10/17/18 at 2:02 pm with Nursing Assistant (NA) #4 revealed she did not give Resident #8 a shower yesterday (10/16/18). She explained she was assigned to give showers and had 20 showers to give on her 7-3 shift. NA#4 explained she had provided 16 of the 20 showers and informed the nurse the showers that were not done. During the interview NA #4 explained residents would be shaved and nail care provided on the day of their shower or when it was needed. Interview with Nurse #4 on 10/18/18 on 1:22 pm revealed she did not work on 10/16/18. Nurse #4 explained the process for showers included the NA ' s would bring the shower sheet for signature that the bath was done. When asked how she would verify a shower was given, she explained if the resident's hair was wet, if they looked or smelled clean. Nurse #4 was asked if Resident	F 677	CNAs. Residents affected verbalized no concerns with bathing type. On 11/5/2018 the Registered Nurse (RN) completed an audit of all resident nails and shaving. All negative findings were addressed by CNAs. Corrective action taken verified by RN on 11/6/2018. On 11/2/18 the director of nursing completed an update to the shower schedule to accommodate for all residents and their preferences. Starting 11/2/2018 the director of nursing will update the shower schedule with each new admission, discharge, and/or change in resident preference. This will ensure all residents are included on the shower schedule. On 10/29/2018 the Staff Facilitator initiated an In-service on Showers/Full bed baths must be provided per resident preference (schedule) for all nursing staff (nurses, medication aides, nursing assistants, and agency staff). The in-service will be completed by 11/9/18. No nursing staff will be allowed to work after 11/9/18 until in-service is completed. This in-service was added to the orientation for all new nursing staff. The director of nursing, assistant director of nursing, and/or registered nurse will audit the resident showers/full bed baths per preference, nails without debris, nails acceptable length, and facial hair based on resident preference using the Bath	

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F 677	Continued From page 6 #8 had been checked for cleanliness, she said no. She then went into the resident ' s room, saw his fingernails and unshaven face, and explained he had not been bathed. Further interview revealed sometimes residents refused baths. Nurse #4 explained the NA ' s were to report any refusals to the nurse. Nurse #4 indicated she had not been informed of any refusals for this resident. 2)Resident #37 was admitted to the facility on 7/15/11 with diagnoses that included stroke with weakness and paralysis to the left side of her body. The Minimum Data Set (MDS) quarterly assessment dated 9/4/18 revealed the resident was cognitively intact, required extensive assistance of one staff member with bed mobility, transfers, dressing, toileting, personal hygiene and one-person total assistance for bathing. Resident #37 had impairment to her upper and lower extremities to one side of her body, used a wheelchair, and was always incontinent of bladder and bowel. A review of the Care Area Assessment dated 3/14/18 revealed Resident #37 triggered for ADLs and her active care plan documented the resident required assistance with ADLs. An observation and interview with Resident #37 on 10/15/18 at 12:16 PM, revealed the resident had greasy hair and she stated that she couldn't remember the last time she had a shower. She stated that she had requested showers, that she had only gotten bed baths during incontinence care, and that her hair was washed with a wet wash cloth on occasion.	F 677	Audit Tool 5 residents daily 5 x per week (to include all shifts) x 12 weeks. The monthly quality improvement (QI) committee will review the results of the Bath audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance performance improvement (QAPI) committee for further recommendations and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction.	

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F 677	Continued From page 7	F 677		

An observation and interview with Resident #37 on 10/16/18 at 10:45 AM revealed the resident had not received a shower. The resident's hair was observed to be greasy.

An observation and interview with Resident #37 on 10/17/18 at 2:45 PM revealed the resident had not received a shower. The resident's hair was observed to be greasy.

An observation and interview with Resident #37 on 10/18/18 at 3:25 PM revealed the resident had not received a shower. The resident's hair was observed to be greasy.

Review of the Shower Book for revealed documentation that Resident #37 had not received a shower from 10/9/18 through 10/18/18.

During an interview with Nurse Aide (NA) #5 on 10/18/18 3:29 stated she could not find documentation of a shower being given in the shower book. Resident #37's room number was not listed on the shower schedule and she stated that could be how her showers was missed. She stated that a shower team did the showers based on the assignment sheet and wouldn't know to give the resident a shower if her room/bed number wasn't listed to be completed.

An interview was conducted with the Director of Nursing (DON) on 10/18/18 at 4:45 pm and she determined that when the new shower schedule sheet was made, the resident's room number was accidently left off of the schedule. It was her expectation that all residents be offered and to be given showers as requested.

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F 677	Continued From page 8	F 677		

3) Resident # 63 was admitted to the facility on 10/3/18. He had diagnoses of: lack of coordination, Non-Alzheimer's dementia, and muscle weakness.

Reviewed Resident # 63's 5-day minimum data set (MDS) assessment dated 10/3/18. Resident had moderate impaired cognition. He required extensive assistance with his activities of daily living (ADLs.) He was not coded for behaviors.

Reviewed Resident # 63's care plan dated 10/11/18 revealed the resident required staff assistance with his personal hygiene and bathing.

On 10/15/18 at 09:49 AM Resident # 63 was observed in his room sitting in his wheelchair. He had long white facial hair, soiled shirt and pants, and his hands and face were dirty.

On 10/16/18 at 01:39 PM Resident # 63 was observed sitting in his wheelchair in the doorway of his room. He had long white facial hair, his hair was uncombed, and he was disheveled and dirty appearing. He was barefooted and was wearing gripper socks on his hands. He had on the same clothes that he had on 10/15/18.

On 10/17/18 at 08:24 AM Resident # 63 observed sitting in his wheelchair in his room. He is had long facial hair, and his hands and face were dirty. He had on the same clothes that he had on 10/15 and 10/16/18
An interview was conducted with NA # 26 on 10/17/18 at 02:37 PM. He said he had not had time to shave or shower Resident # 63 because

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F 677	Continued From page 9 he had been busy. An interview was conducted with Nurse # 50 on 10/17/18 at 03:12PM. She was unware if Resident # 63 had received a shower or had been shaved. An interview was conducted on 10/17/18 at 04:32 PM with the assistant director of nursing (ADON.) She said she had asked the staff earlier in the day to shave Resident # 63, but she would make sure it was done. On 10/18/18 at 08:11 AM Resident # 63 was observed sitting on his bed. He had long white facial hair above his lip. The resident's cheeks and chin had been shaved. He had beard particles scattered all over the front of the same pants that he was observed wearing on 10/15, 10/16, 10/17 and 10/18/18. Reviewed Resident # 63's shower documentation. Resident had showers scheduled on day shift on Mondays and Wednesdays. From 10/5-10/18/18 resident had showers documented two days on 10/8 and 10/18/18. On 10/18/18 at 02:46 PM an interview conducted with the director of nursing (DON.) She was unaware Resident # 63 only had two documented showers in the last two weeks, and that he also had long facial hair. She said her expectations were for resident to receive showers as scheduled and shaving and personal hygiene provided as needed..	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/8/18

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F 684	Continued From page 10 § 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 and staff interview the facility failed to provide Resident #49 thickened liquids according to the physician's order for one of two sampled residents reviewed for swallowing problems. The findings included: Review of the physician monthly orders for 8/1/18 indicated Resident #49 was to receive nectar thickened liquids. Resident #49 was readmitted to the facility from the hospital on 8/31/18 with diagnoses of chronic lung disease, Alzheimer's dementia, pacemaker insertion and dysphagia. Review of the quarterly Minimum Data Set (MDS) dated 9/12/18 indicated she required extensive assistance for bed mobility, transfer, toileting and personal hygiene. She required supervision with set up help for eating. This MDS indicated she had short and long-term memory impairment and no behaviors. The care plan dated 9/12/18 included a problem of nutritional risk with interventions for staff to	F 684	F tag 684 The plan of correcting the specific deficiency The position of Piney Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow the facility established protocol related providing residents with thickened liquids according to physicians orders due to knowledge deficit related to failure to provide education and reinforcement of education on thickened liquid procedures. On 10/16/2018 the assistant director of nursing (ADON) obtained a physician order for resident #49 that clarified resident□s thickened liquid status as honey thick liquids. On 10/16/2018 the ADON completed a diet order slip contained the physician ordered thickened liquid for resident #49 and provided to the kitchen for follow up.	

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F 684	Continued From page 11 assist with meals when she became tired, aspiration precautions and honey thickened liquids. A telephone order dated 9/27/18 by the Registered Dietician indicated an order for supplements was changed due to a change in the thickened liquid consistency. The order indicated the liquid supplement would not be at a honey consistency and it was changed to a pudding. The monthly physician's orders dated 10/1/18 included a diet order for Regular, puree, enriched foods with honey thick liquids. Review of the October 2018 Medication Administration Record included honey thick liquids. Observations on 10/15/18 at 12:15 PM revealed Resident #49 had nectar thick liquids on her tray for lunch. The tray ticket indicated Resident #49 was to receive nectar thick liquids. Observations on 10/16/18 at 8:49 AM revealed the tray ticket indicated Resident #49 was to receive nectar thick liquids. The liquid provided was pre-packaged nectar thick liquids. Observations on 10/17/18 at 8:30 AM of Resident #49's breakfast tray revealed the tray ticket read nectar thick liquids. The beverage served was coffee and was a thick, pudding like consistency. Interview with Nursing Assistant (NA) #3 on 10/17/18 at 8:40 AM revealed the liquids came from dietary pre- thickened. NA #3 explained she was not sure of the consistency of the resident's coffee, but it looked like honey. NA #3 further	F 684	On 11/5/2018 the Administrator observed the meal tray for resident #49 and the thickened liquid ordered by the physician was present on the tray sent from the kitchen. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/17/2018 the ADON completed an audit of all residents on thickened liquids to ensure the physician order and the diet order slip matched and the thickened liquids provide on the meal tray was correct. There were no additional negative findings. On 11/6/2018 the staff facilitator began an in-service with all nursing staff, including agency, on thickened liquids must be provided as ordered by the physician. This in-service will be completed by the ADON, director of nursing (DON), and or registered nurse by 11/8/18. No nursing staff will be allowed to work after 11/8/18 until in-service is complete. This in-service was added to the orientation for all newly hired nursing staff, including agency. On 11/5/2018 the staff facilitator began an in-service with all nursing staff and dietary staff, including agency, on supplements must be provided as ordered (including thickened liquids). This in-service will be completed by 11/8/18 by the DON, ADON, and/or registered nurse. After 11/8/18 no nursing, or dietary staff, including agency	

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F 684	Continued From page 12 explained she was not familiar with the thickened liquids, she went by what the kitchen sent out to the floor. Interview with the Dietary Manager (DM) on 10/17/18 at 8:50 AM revealed Resident #49 was to have honey thick liquids. She explained the physician orders in the electronic record had nectar and had not been changed. Further interview revealed the ticket would have the honey thick liquids listed. Upon inspection of the resident's tray ticket with the DM on 10/17/18 at 8:58 AM, the tray ticket read "nectar." The DM explained a communication form from nursing, dated 10/16/18, had been given to her that day. The communication form indicated Resident #49 was to have honey thick liquids with meals. The DM explained the tray ticket had not been changed, and breakfast on 10/17/18 would have been the first time to receive honey thick. Interview with the Registered Dietician (RD) on 10/17/18 at 3:51 PM revealed she saw the resident on 9/27/18 after readmission to the facility from a hospitalization. The discharge physician orders from the hospital listed liquids as "honey thick liquids." She saw Resident #49 was on nectar thick supplement and wrote the order for the change from a nectar to the pudding supplement. The communication form would be sent from nursing if there were changes in orders or recommendations for dietary. The RD explained dietary kept the communication forms in a file box in the DM's office. Further interview revealed the RD came to the facility once a month and she did not review the communication forms. She explained she would ask the DM if a	F 684	will be allowed to work until in-service is completed. This in-service was added to the orientation for all newly hired nursing and dietary staff including agency. On 11/5/2018 the staff facilitator began an in-service with licensed nurses, including agency, on communicating registered dietitian recommendation to dietary using dietary slip. This in-service will be completed by 11/8/18 by the ADON, DON, and/or registered nurse. After 11/8/18 no licensed nurse will be allowed to work until in-service is complete. This in-service was added to the orientation for all newly hired licensed nurses including agency staff. On 11/5/2018 the staff facilitator began an in-service with all nursing staff, including agency that the meal tray must be checked to ensure the meal provided is accurate and complete based on the tray card (includes thickened liquids and supplements). This in-service will be complete by 11/9/18 by the ADON, DON, and/or registered nurse. No staff will be allowed to work after 11/9/18 until in-service is complete. This in-service was added to the orientation for all newly hired nursing staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 11/9/18 the DON, ADON, administrator, dietary manager, and/or	

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F 684	Continued From page 13 communication form was received from nursing upon Resident #49's return from the hospital. Interview with the RD on 10/17/18 at 3:32 PM revealed dietary received a communication form dated 8/31/18, which indicated nectar thick liquids. Interview on 10/17/18 at 4:00 PM with the Director of Nursing revealed she did not know why dietary was notified of nectar thick liquids after returning from the hospital. She explained she would have to check into the matter.	F 684	registered nurse will audit 3 meal trays daily 5x weekly (to include 7 days, and all 3 meals) x 12 weeks to ensure liquids (including thickened liquids) were provided as ordered by the physician. This audit will be documented on the liquid audit tool. The monthly quality improvement(QI) committee will review the results of the liquid audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance performance improvement (QAPI) committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		11/21/18

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F 689	Continued From page 14 §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 interviews with residents, family members and facility staff, the facility failed to secure smoking materials per the facility's Smoking Policy and failed to intervene and remove a resident from his room that was observed with smoke in it for 1 of 3 (Resident #315) residents reviewed for smoking. The failure to ensure smoking materials were secured resulted in Resident #315, who required continuous oxygen, receiving first degree burns to his hands and face and could have caused an adverse outcome to other residents residing in the facility. Findings included: Resident #315 was originally admitted to the facility on 6/29/18 with diagnoses of bipolar disorder, schizophrenia, chronic pain, hypertension, sleep apnea and chronic obstructive pulmonary disease and pulmonary fibrosis. He was readmitted to the facility on 10/10/18 with diagnoses of first degree, partial thickness burns to his lip, chin and hand. A review of the Smoking Policy dated 2/1/18 section "Smoking Materials": All resident smoking materials are maintained in a secured area and are accessible only through the assistance of the facility's staff. These measures are necessary to ensure the safety of the facility's smoking and non-smoking residents. Residents and/or visitors may not provide	F 689	Past noncompliance: no plan of correction required.	

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smoking materials at any time to other residents.

Review of the admission Minimum Data Set (MDS) assessment dated 7/3/18 revealed Resident #315 was independent with ambulation, cognitively intact and had no behaviors.

A review of the care plan dated 7/16/18 revealed Resident #315 was an independent and safe smoker with a goal to continue smoking safely in designated areas through next review. Interventions included: assist resident in obtaining smoking materials from secured storage area upon request, evaluate resident's continued ability to smoke safely on a consistent and regular basis, observe for potential violations of the smoking policy, oxygen removal prior to smoking per physicians order, resident may smoke at times of own choice in designated smoking areas, resident may smoke independently without supervision, upon return of smoking materials by resident, ensure materials are placed in secured storage area.

A smoking assessment was completed on 7/11/18 that deemed Resident #315 to be a safe smoker.

A review of an incident report dated 9/30/18 revealed NA #2 reported smelling smoke in room and resident had blister on lip. Per resident, he was burning the hems on his clothes. The physician was notified and an order was given to apply petroleum jelly to the affected areas. Cigarettes and lighter were removed from the residents room, the resident was informed of the smoking policy. The resident's sister was notified and the Director of Nursing (DON) was called.

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A statement given by NA #2 revealed she was walking up the middle hall and smelled smoke. She opened the door and the room was full of smoke and went to tell the charge nurse.

A phone interview on 10/17/18 at 7:15 PM with NA #2 revealed on the evening of 9/30/18 at about 9:30 PM, she was walking by Resident 315's room and smelled smoke. She stated she opened the door and saw smoke and a flame from a lighter. She stated that she immediately went to the front hall to get the charge nurse.

A statement given by Nurse #1 revealed on 9/29/18 NA #2 came on the front hall to tell him she smelled smoke coming from Resident #315's room. He went to the room and asked Resident #315 if he was smoking cigarettes. Resident #315 stated no, he said he was burning the hems off his pants leg, but he was wearing shorts. Resident #315 stated he burned his lip, chin and left palm. Nurse #1 called the DON, and the physician and was given a verbal order to apply petroleum jelly to the areas and monitor.

A nurses note dated 9/29/18 at 9:22 PM by Nurse #1 revealed NA #2 came to get the nurse because she smelled smoke coming from Resident #315's room. The resident stated he was burning the hems from his pants legs although he wasn't wearing pants. The nurse instructed the resident to give him his lighter. The nurse called the Director of Nursing (DON) to inform her of the situation and was instructed to remove the cigarettes and lighter.

An interview on 10/18/18 at 7:30 AM with Nurse #1 revealed the resident's cigarettes and lighters were kept at the nurse's station and the residents

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asked the nurses when they wanted to smoke. He was unaware Resident #315 had cigarettes in his room. On 9/30/18 he went to the room after NA #2 came to get him because she smelled smoke, he asked Resident #315 was he smoking and the resident stated no, he was burning hems off of his pants. Nurse #1 observed a burned area to his bottom lip, chin and left palm. He called the DON and the physician and was instructed to apply petroleum jelly to the areas and monitor. He removed cigarettes and lighter from the room.

A nurse's note dated 9/30/18 at 8:40 AM by Nurse #2 revealed she followed up on Resident #315's burns on his left hand and face. The physician, Hospice representative and family were notified and the physician gave a telephone order to send the resident to the emergency department. The administrative staff on duty notified the Administrator. Nurse #2 provided education about smoking rules, non-compliance and dangers of smoking with oxygen on. The resident stated he was sorry and didn't want to hurt anyone.

An observation on 10/15/18 at 11:31 AM of room 127B (Resident #315's room) revealed NA #1 sitting outside of the door. The door was open and Resident #315 was sitting on the side of his bed with his guitar in his lap.

An interview on 10/15/18 at 11:31 AM with NA #1 revealed Resident #315 was on 1:1 observation because "he did something he wasn't supposed to".

An observation on 10/15/18 at 11:32 AM of Resident #315 in his room revealed oxygen at 4 liters per minute in use. The resident had a scabbed area to his chin, left hand and upper lip.

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An interview on 10/15/18 at 11:32 AM with Resident #315 revealed he had a little accident. He stated he was smoking in his room with his oxygen on and when he lit the lighter, it ignited. He stated he obtained the cigarettes and the lighter from the store and had a couple of packs in his room and a lighter. He revealed the he was sorry and would never do it again.

An interview on 10/17/18 at 1:51 PM with Nurse #3 revealed all of the smokers in the facility are safe to smoke independently, but they keep their cigarettes and lighters locked in the medication cart and the residents ask for them when they want to smoke. She revealed Resident #315 would either turn on his call bell or come out into the hall to request a cigarette.

An interview on 10/18/18 at 8:45 AM with Medication Aid #1 revealed that before the incident Resident #315 would call out or come out into hallway to get a cigarette. She stated that he would bring them back when he came back in but sometimes needed reminding.

A phone interview on 10/18/18 at 9:02 AM with Resident #315's family member revealed she would bring the resident cigarettes at times and not leave them with the nurse. She stated she wasn't aware they kept the cigarettes locked up until a couple of weeks ago.

An interview on 10/18/18 at 9:30 AM with the Administrator revealed prior to this incident, Resident #315 was assessed and able to smoke independently. She revealed the cigarettes and lighters were kept at the nurse's station for all smokers. She indicated that the resident's sister

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may have brought cigarettes in to the resident, but her expectation was the smoking policy be followed.

The Administrator provided the Plan of Correction on 10/18/18 at 3:54 PM

Plan of Correction:
On 9/29/18, the smoking materials in the resident's possession were removed from the room. The resident was educated that he was not allowed to smoke in the facility and around combustible material such as his oxygen. Root cause was the resident did not return his cigarettes and lighter to the nurse due to his non-compliance with the smoking policy. Upon reentry to the facility from a local hospital on 10/10/18, the Administrator educated the resident and the sister who was present on the smoking policy and informed them the resident was now a supervised smoker and would require on 1:1 sitter at all times as long as resident remains in the facility. He was assessed and determined that he was a supervised smoker. His care plan was updated to reflect current status by the MDS coordinator.

On 9/30/18, the MDS nurse, the hall nurse and the medication aide checked all resident rooms for any smoking materials and/or lighters or sources of ignition. The 100% check of resident rooms revealed one other resident, who was in the hospital, had cigarettes and a lighter in her room. The cigarettes and lighter were removed from the room.

On 9/30/18, all present smokers were assessed by the MDS nurse and determined to be safe smokers. During the assessment, it was

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determined that a monthly assessment for independent smokers had not been completed per policy by the MDS coordinator.

On 9/30/18, smokers were provided with education on the smoking policy by licensed nurse. This education is documented in the smoking assessment section B.

On 9/30/18, the staff facilitator initiated an in-service on the smoking policy, which included a section on smoking materials and that smoking is prohibited inside the facility and in any areas where flammable liquids, combustible gases or oxygen are in use or stored, for 100% staff (all departments, nurses, medication aides, nursing assistants, contracted staff, agency staff). The in-service included what staff are to do if they smell or see smoke. Also included in the in-service was monthly assessments for independent smokers and quarterly for supervised smokers. The in-service was completed on 10/4/18. Beginning 10/4/18, the staff facilitator will cover the smoking policy in new employee orientation, including agency staff.

On 9/30/18, the MDS coordinator completed a smoking evaluation on all residents who smoke to determine if they are a safe smoker or require supervision. Beginning 9/30/18, the admissions coordinator, social worker and/or nurse will review the smoking policy with all newly admitted residents. Also beginning 9/30/18, the admissions coordinator, social worker and/or nurse will complete a smoking assessment on all newly admitted residents that smoke to determine if they are a safe smoker or require supervision. With each smoking assessment the resident will be provided with re-education on the smoking

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policy. This will be documented on the smoking assessment section B.

Beginning 9/30/18, the interdisciplinary team (IDT) committee members will review all new resident admissions. The review will include the review of the smoking policy and smoking assessments if the resident smokes. The IDT committee will perform the review the next business day after the resident's admission. Admission assessments will be reviewed by the IDT to ensure completion of all assessments, including the smoking assessment. The results of the IDT review will be brought before the Quality Assurance and Performance Improvement (QAPI) team to review for any further interventions and/or monitoring.

A QAPI meeting was held on Friday 10/5/18 to review the plan of correction for smoking in the room with oxygen. Meeting also reviewed resident involved had a lighter and cigarettes in room, non-compliant with smoking policy.

The DON and/or the Assistant Director of Nursing (ADON) will review each new admission including smoking assessment within 72 hours of completion to ensure education was provided to resident and/or resident representative per smoking policy, the care plan is appropriate related to smoking using Admission Audit Tool. The Administrator will review this audit weekly using the Admission Audit Tool.

The DON and/or the ADON will review each resident that smokes monthly to ensure smoking assessments are current per policy, resident and/or representative education per smoking policy and the care plan is appropriate related to

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smoking using the Smoking Audit Tool. The administrator will review the Smoking Audit Tool monthly to ensure smoking assessments are current per policy, resident and/or representative education per policy and the care plan is appropriate related to smoking using the Smoking Audit Tool.

The MDS nurse, DON and/or Weekend Manager on duty will audit three resident rooms daily 5 times per week for 12 weeks to ensure no smoking paraphernalia is in resident's rooms. Any negative findings will be immediately addressed by auditor and appropriate resident specific interventions put into place. This audit will be documented on the Smoking Materials in Room Audit Tool. The Administrator will review audit tools weekly.

The facility will ensure that independent smokers return their cigarettes and lighters with the Smoking Materials in Room Audit tool and the completed Monthly Smoking Assessment including education on the smoking policy. The smoking policy education that will be provided will include returning cigarettes and lighters to the nurse.

The Administrator will be responsible for implementing the acceptable plan of correction.

The plan of correction was verified on 10/18/18 as evidenced by:

Review of smoking assessments for the three residents in the facility that smoked dated 9/30/18. All three assessed as safe smokers and educated on smoking policy and care plans updated. Resident #315 assessed upon reentry

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F 689	Continued From page 23 to the facility on 10/10/18, educated and deemed unsafe to smoke without supervision. Care plan updated on 10/1/18. Review of documentation by Administrator on 10/10/18 in Resident #315's electronic record on education of smoking policy of Resident #315 and family member. Review of new admissions since 9/30/18 indicated no new admissions that smoked. Review of all staff in-service sign in sheets for in-service titled "Smoking Policy" dated 9/30/18 by the staff facilitator and on 10/1/18 by the Administrator. Review of Smoking Materials in room audit tool completed for 10/1/18 through 10/18/18.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to obtain an order for the administration of oxygen for a resident on continuous oxygen (Resident #49) in a sample of two residents reviewed for oxygen administration.	F 695	F695 The plan of correcting the specific deficiency	11/8/18

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F 695	Continued From page 24 The findings included: Review of Resident #49 ' s medical record revealed the August 2018 monthly orders signed by the physician included oxygen at 2 liters per minute continuous. Further review of the medical record revealed Resident #49 was discharged from the facility to a local hospital on 8/29/18 due to a slow heart rate. Resident #49 was readmitted to the facility from the hospital on 8/31/18 with diagnoses of chronic lung disease, Alzheimer ' s dementia, pacemaker insertion and dysphagia. Review of the readmission orders on 8/31/18 and monthly orders for 9/1/18 the order for oxygen usage was not present. Review of the quarterly Minimum Data Set (MDS) dated 9/12/18 indicated she required extensive assistance for bed mobility, transfer, toileting and personal hygiene. This MDS indicated she had short and long-term memory impairment, no behaviors and use of oxygen. The care plan dated 9/12/18 included a problem of chronic pulmonary disease, hypoxia and pneumonia. The interventions included use of oxygen via nasal cannula as ordered by the physician. Record review of the October 2018 Medication Administration Record recorded Resident #49 ' s oxygen saturation levels that were 90 percent.	F 695	The position of Piney Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to ensure oxygen was provided per physician order was staff failure to follow established policy related to physician orders related to knowledge deficit from failure to re-inforce education. On 10/18/2018 the Licensed Practical Nurse obtained a physician order for resident # 49□s oxygen. O2 therapy continuously via nasal cannula at 2 liters per minute. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 11/5/2018 the Registered Nurse audited all residents□ room for oxygen concentrator and/or portable oxygen tank presence. Filters were dirty, tubing with no dates and NS bottles without dates. All filters were cleaned, new tubing replaced and dated and NS bottles were replaced and dated. On 11/5/2018 the Registered Nurse used the room audit for oxygen to ensure physician orders were present. On 11/5/2018 the Registered Nurse audited all residents with physician orders for oxygen to ensure oxygen is provided as ordered. Five residents required clarification from the Physician which was received by the director of nursing (DON) on 11/5/2018.	

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F 695	Continued From page 25 Observations of Resident #49 on 10/15/18 at 11:00 AM revealed she was in an activity out of her room. There was a portable oxygen tank on the back of her wheelchair and the oxygen tank was not turned on and the resident was not wearing the oxygen. Observations of Resident #49 on 10/16/18 at 10:32 AM revealed Resident #49 was not wearing her oxygen via nasal cannula. The oxygen concentrator was on and operating, and the nasal cannula was across the concentrator. Observation of Resident #49 on 10/16/18 at 12:15 PM revealed she was in her room, eating lunch and the oxygen was not in use. Interview with the Director of Nursing on 10/18/18 at 12:14 PM revealed she would expect the nurse to ask for clarification/orders for a resident that was readmitted without an order for oxygen, and previously had orders for oxygen.	F 695	On 11/5/2018 the director of nursing (DON), assistant director of nursing (ADON), and/ or registered nurse began in-service for all licensed nurses, including agency, on providing oxygen per physician order. The in-service will be completed by 11/9/18. No staff will be allowed to work after 11/9/18 until in-service is completed. This in-service was be added to the orientation for all new nursing staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, and/or registered nurse will audit 5 residents daily 5x per week (to include all 7 days per week) x 12 weeks to ensure if oxygen is use the oxygen is being used per physician order. The audit will be documented on the oxygen audit tool. The monthly quality improvement (QI) committee will review the results of the oxygen audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality improvement	

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F 695	Continued From page 26	F 695	performance improvement (QAPI) committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a resident's bed in safe operating condition for 1 of 1 sampled residents for equipment safety. (Resident # 10) Findings: An observation of Resident # 10 's bed on 10/15/18 at 09:51 AM revealed the left side of the headboard was unattached, hanging down, and the metal frame that held the headboard was exposed. An observation of Resident # 10 's bed on 10/16/18 at 02:00 PM revealed the left side of the headboard was unattached, hanging down, and the metal frame that held the headboard was exposed.	F 908	F908 The plan of correcting the specific deficiency The position of Piney Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to maintain bed in safe operating condition was staff failure to follow facility protocol in reporting and repairing damaged bed due to knowledge deficit related to failure to educate staff. On 10/17/18 resident #10□s headboard was repaired by facility maintenance. The procedure for implementing the acceptable plan of correction for the	11/8/18

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F 908	Continued From page 27 An interview was conducted with nursing assistant (NA) # 25 on 10/16/18 at 04:26 PM. She was unaware that Resident # 10's headboard was unattached and hanging from the bed frame. An interview was conducted with the assistant director of nursing (ADON) on 10/16/18 at 04:29 PM. She was unaware that Resident # 10's headboard was unattached and hanging from the bed frame. She said that she would put in a maintenance request for the headboard to be repaired. An observation of Resident # 10 's bed on 10/17/18 at 08:32 AM revealed the left side of the headboard was unattached, hanging down, and the metal frame that held the headboard was exposed. On 10/17/18 at 09:01 AM the Maintenance Director was observed carrying a headboard out of Resident # 10's room. He said he had received a maintenance request on 10/16/18 to repair the headboard, and he replaced it this morning. An interview was conducted on 10/18/18 at 02:38 PM with the director of nursing (DON) who was unaware Resident # 10's headboard needed to be repaired. She said her expectation was the headboard should have been replaced/repaired as soon as it was reported.	F 908	specific deficiency cited On 10/23/18 all occupied resident beds were audited by facility consultant for safe operating conditions of headboards with no additional negative findings noted. On 11/5/2018 the staff facilitator began an in-service with all staff, including agency, on reporting broken equipment using the facility TELs system (reporting system used by facility to notify maintenance of broken equipment, track repairs, and ensure timely repair). The in-service will be completed by 11/9/18. No staff will be allowed to work after 11/9/18 until in-service is completed. This in-service was added to the orientation for all new staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, social worker, admission coordinator, dietary manager, director of nursing, assistant director of nursing, minimum data set nurse, and/or maintenance employee will audit 10 random resident□s rooms daily x 5 days per week (to include all 7 days) x 12 weeks using the Administrative Staff/ Department Head Rounds Sheet. Any negative findings will be placed into the TEL system to ensure it is repaired. The Administrator will review audit tools weekly.	

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F 908	Continued From page 28	F 908	The monthly quality improvement (QI) committee will review the results of the Administrative Staff/Department Head Rounds Sheet for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance performance improvement (QAPI) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	