STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of	F 565	Disclaimer:	12/27/18

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

Electronically Signed | 12/22/2018

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F 565	Continued From page 1 resident council meeting minutes and resident and staff interviews the facility failed to address an ongoing grievance of the resident council concerning call bell response and failed to implement a response to a resident council concern regarding soggy rolls. The findings included: 1. Review of resident council meeting minutes from May 2018-November 2018 noted that four of seven months a concern with call bell response was voiced by resident council members in the monthly meeting. These concerns and the facility response included: May 4th, 2018-Residents stated call bells were being turned off and staff stated they would be right back and staff did not return. In response to the concern, an inservice was done with nursing assistants on 05/08/18 to tell them call bells should be answered timely and that lights should not be turned off until resident needs were met. June 8th, 2018-Residents stated nursing assistants were taking too long to answer call lights. In response to the concern, an inservice was done with nursing assistants on 6/8/18 on appropriate call light response times and increased "rounding" on units. August 10th, 2018-Residents stated nursing assistants were turning off call bells and telling residents they would return and staff did not come back. In response, an inservice was done with nursing assistants on 8/10/18 about answering call lights timely and to leave the call light on until resident needs were met. November 9th, 2018-Residents stated they were waiting too long for call bell response. In response, on 11/9/18 an inservice was done with staff about answering call bells.	F 565	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is submitted solely because it is required by the provision of federal and state law. F565 – Resident / Family Group and Response CFR(s) : 483.10(f)(5)(i)-(iv)(6)(7) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 12/22/18, Administrator and DON reviewed Resident Council meeting minutes for timeframe May 2018 to November 2018 pertaining to soggy rolls and call light response times. The Dietary Manager implemented the use of bread bags per resident council request on 11/30/18 to prevent rolls from become soggy on resident trays. The DON/Admin implemented a call bell action plan to further investigate the root cause of multiple call bell concerns. Resident Council attendees were informed of the resolution of the grievances on 12/21/18. Documentation of resolution and communication to attendees was included in the Resident Council meeting minutes. On 12/22/18 the DON educated that all staff (both clinical and non-clinical) should answer call lights and to ensure to leave it	

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F 565	Continued From page 2 On 11/29/18 from 10:30 AM-11:30 AM a meeting was held with members of the resident council. Eight of eight residents present and participating in the resident council meeting reported that call bell response was an ongoing issue. In addition, the residents reported the only response they ever heard about their concern with call bell response was staff education. Residents reported staff continued to turn off the call bell, didn't ask what the residents concern was (to see if it was an emergency) and left the room and sometimes didn't come back. Residents reported recently waiting as long as two hours for staff to respond to a call bell. On 11/29/18 at 3:00 PM the Activity Director stated she assisted the resident council during the monthly meetings to take notes and report concerns to appropriate department heads. The Activity Director stated at the beginning of each resident council meeting she reviewed concerns from the prior month to ask residents if the concern was resolved. The Activity Director stated the concern about call bells reported by resident council in May 2018, June 2018, August 2018 and November 2018 had been reported to the Director of Nursing. The Activity Director stated the response from nursing management to the resident council concerns about call bell response had been staff education. On 11/29/18 at 3:30 PM the former interim Director of Nursing stated the former Director of Nursing addressed the call bell concern reported by resident council in May 2018, June 2018 and August 2018. The former interim Director of Nursing stated staff were inserviced about call bell response after concerns were reported by	F 565	on until the need is met and to always leave one staff member on the hall at all times to answer call bell lights. On 12/22.18 the Administrator implemented a call bell audit on all three shifts to ascertain where the issues exist so the facility can better strategize what interventions to put in place. Beginning on 12/22/18, a dedicated staff member will be assigned on the daily assignment sheets who is responsible for answering lights during that shift. It is the facility's practice for the Activities Director to facilitate and communicate Resident Council grievances to ensure prompt resolution. Recent turnover in the Activities Director position led to a lapse in communication as to who manages Resident Council grievances, which led to failure of the facility's practice of monitoring and responding to resident grievances timely. (2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Ad-hoc Resident Council meeting held on 12/21/18 by Activities Director to determine if any other residents had unresolved concerns. Residents (Residents present included: #12; #9; #284; #43) were in attendance at the resident council meeting. No other new grievances noted during meeting. Residents were informed of the use of the bread bags and the implementation of the Call bell action plan.	

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F 565	Continued From page 3 resident council. Because she had not served as interim Director of Nursing until August 2018 the former interim Director of Nursing stated with all the recent changes with management staff she didn't realize the resident council concern about call bell response had been an ongoing concern. On 11/29/18 at 3:45 PM the Administrator stated she started working at the facility August 2018. The Administrator stated she attended the August 2018 resident council meeting and was aware of the resident council concern about call bell response reported in the August meeting. The Administrator stated she did not realize call bell response had been an ongoing concern and would expect a different intervention to address repeated resident council grievances. 2. Review of resident council meeting minutes noted that a concern about soggy rolls had been reported 7/13/18 in the resident council meeting. Resident council meeting minutes dated 8/10/18 noted the former Food Service Director attended the meeting and told residents dietary staff would be inserviced about draining vegetables better as well as using bread bags for rolls. On 11/29/18 from 10:30 AM-11:30 AM a meeting was held with members of the resident council. Eight of eight residents present and participating in the resident council meeting reported they had complained about soggy rolls in the 7/13/18 resident council meeting and, in response, were told dietary staff would put rolls in bread bags. Eight of eight residents in the resident council meeting stated they never saw any bread bags and continued to receive soggy rolls.	F 565	On 12/18/18, Administrator completed in-service education with department head team (including Activities Director) on (1) timely and proper follow up of Resident Council concerns and (2) ensuring to review previous interventions and make sure to implement different interventions if previous did not work, and (3) . (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Beginning 12/17/18, audits of resident council minutes / concerns (grievance log) will be conducted (we need to be checking this weekly x 1 month at first) then monthly x 3 months by Administrator for proper follow up of concerns. Any noted issues during audits will be addressed at that time with the Activities Director or respective department head. On 12/22/18 the DON educated that all staff (both clinical and non-clinical) should answer call lights and to ensure to leave it on until the need is met and to always leave one staff member on the hall at all times to answer call bell lights. On 12/22/18 the Administrator implemented a call bell audit on all three shifts to ascertain where the issues exist so the facility can better strategize what interventions to put in place. Beginning on 12/22/18, a dedicated staff member will be assigned on the daily assignment sheets who is responsible for answering	

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F 565	Continued From page 4 On 11/29/18 at 3:00 PM the Activity Director stated she assisted the resident council during the monthly meetings to take notes and report concerns to appropriate department heads. The Activity Director stated the concern about soggy rolls was brought up by resident council 7/13/18. The Activity Director stated the concern was reported to the former dietary manager and that dietary manager attended the 8/10/18 resident council meeting and reported dietary staff would place the rolls in bread bags. On 11/29/18 at 3:15 PM a former interim dietary manager/cook stated the former dietary manager that attended the 8/10/18 resident council meeting no longer worked at the facility. The former interim dietary manager/cook stated he served as the interim dietary manager until recently when another manager was hired. The former interim dietary manager/cook stated the former dietary manager (that attended the 8/10/18 resident council meeting) did not tell him or staff about using bread bags for all residents. The former interim dietary manager/cook stated they had a box of bread bags and only were aware of one resident that wanted his bread in a bread bag. The former interim dietary manager/cook stated they would have been glad to use the bread bags for all residents, they just didn't know. On 11/29/18 at 3:45 PM the Administrator stated she started working at the facility August 2018. The Administrator stated she attended the August 2018 resident council meeting and was aware of the resident council concern about soggy rolls and recalled the former food service manager stated they would begin putting rolls in bread bags. The Administrator stated she was in the	F 565	lights during that shift. Effective 12/27/18, audit findings for Resident Council Meeting Concerns will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. The Call bell action plan will be reported on and monitored in the monthly QAPI meeting until the QA committee and the resident council feels it has been resolved. The DM will bring her bread bag auditing tool to QA to report and monitor on monthly and until the QA committee and resident council feels it has been resolved. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	

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F 565	Continued From page 5 dining room every day and had not noticed bread bags in use. The Administrator stated until brought to her attention, she had forgotten about the former food service director telling the resident council of plans to use bread bags. The Administrator stated she expected staff to follow through on interventions to address resident concerns which would have included use of bread bags to prevent soggy rolls.	F 565		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 7 of 9 residents (Resident #33, Resident #34, Resident #46, Resident #8, Resident #45, Resident #24 and Resident #65) identified as a PASRR Level II. Findings included: 1. Resident #33 was admitted to the facility on 05/24/16 with diagnoses of depression. A review of the annual Minimum Data Set (MDS) assessment dated 01/16/18 indicated Resident #33 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a	F 641	F641 – Accuracy of Assessments CFR(s):483.20(g) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18, Regional MDS Coordinator made corrections to the following residents' MDS assessments to accurately reflect a Level II PASRR: #33; #34; #46; #8; #45; #24; and #65. They were accepted by CMS on 11/28/18. It is the facility's practice for the SSD to accurately code / submit resident data on each resident's PASSR status. SSD was not validating PASSR status within the NC MUST system at the time of assessment prior to MDS submission which led to this deficient practice. (2) The procedure for implementing the	12/27/18

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F 641	Continued From page 6 determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 11/27/18 at 9:17 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for coding Section A1500 and missed coding Resident #33 was determined as PASRR Level II on the annual MDS assessment dated 01/16/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #33 was determined as PASRR Level II. The SW stated she would need to submit a modification to the annual MDS assessment dated 01/16/18 to indicate Resident #33 was determined as PASRR Level II. On 11/27/18 at 10:09 AM an interview was conducted with the interim Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 01/16/18 would have been accurately coded to reflect Resident #33 was determined as PASRR Level II. The DON stated it was her expectation that the Social Worker would submit a modification to the annual MDS assessment dated 01/16/18 to indicate Resident #33 was determined as PASRR Level II. On 11/27/18 at 12:58 PM an interview was conducted with the Administrator who stated her expectation was that the annual MDS assessment dated 01/16/18 would have been accurately coded to indicate Resident #33 was PASRR Level II. The Administrator stated her expectation was that the Social Worker would submit a modification to the annual MDS assessment dated 01/16/18 to indicate Resident	F 641	acceptable plan of correction for the specific deficiency cited: On 11/28/18, Social Services Director completed a 100% audit of all inhouse residents of their PASRR levels and confirmed these were correct. All residents that were affected by deficient practice were corrected by the Social Services Director on this date. On 11/28/18, the Social Services Director contacted the State of North Carolina's Department of Health for up to date guidelines on PASRR assignments per Level II guidelines vs Level I. In addition, she downloaded the manual to review in order to better recognize the Level II PASRR identifiers. On 12/19/18, the Administrator educated Social Services Director on the following expectations 1) upon admission to double check the PASRR to ascertain if follow-up is needed 2) to maintain a PASRR log with all current resident's most up-to-date PASRR printouts via NC Must. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Beginning 12/24/18, the Administrator or designee will audit the PASRR book for new admission PASRRs ones weekly for four weeks; then twice a month for one month; then once a month for one month. Any issues discovered will be corrected at that time. Beginning 12/24/18, MDS Coordinator or	

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F 641	Continued From page 7 #33 was PASRR Level II. On 11/28/18 at 3:08 PM an interview was conducted with the MDS Coordinator who stated the annual MDS assessment dated 01/16/18 should have been coded by the SW to reflect Resident #33 was PASRR Level II. 2. Resident #34 was admitted to the facility on 04/20/18 with diagnoses of depression. A review of the admission Minimum Data Set (MDS) assessment dated 04/27/18 indicated Resident #34 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 11/27/18 at 8:58 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for coding Section A1500 and missed coding Resident #34 was determined as PASRR Level II on the admission MDS assessment dated 04/27/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #34 was determined as PASRR Level II. The SW stated she would need to submit a modification to the admission MDS assessment dated 04/27/18 to indicate Resident #34 was determined as PASRR Level II. On 11/27/18 at 10:05 AM an interview was	F 641	Regional Clinical Reimbursement Consultant will conduct random audit of no less than 5 MDS Assessments prior to submission to validate correct PASRR coding once weekly for 4 weeks, then twice a month for one month, then once a month for one month. Effective 12/27/18, audit findings of the PASRR audits will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	

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conducted with the interim Director of Nursing (DON) who stated her expectation was that the admission MDS assessment dated 04/27/18 would have been accurately coded to reflect Resident #34 was determined as PASRR Level II. The DON stated it was her expectation that the Social Worker would submit a modification to the admission MDS assessment dated 04/27/18 to indicate Resident #34 was determined as PASRR Level II.

On 11/27/18 at 1:06 PM an interview was conducted with the Administrator who stated her expectation was that the admission MDS assessment dated 04/27/18 would have been accurately coded to indicate Resident #34 was PASRR Level II. The Administrator stated her expectation was that the Social Worker would submit a modification to the admission MDS assessment dated 04/27/18 to indicate Resident #34 was PASRR Level II.

On 11/28/18 at 3:12 PM an interview was conducted with the MDS Coordinator who stated the admission MDS assessment dated 04/27/18 should have been coded by the SW to reflect Resident #34 was determined as PASRR Level II.

3. Resident #46 was admitted to the facility on 07/03/18 with diagnoses including anxiety disorder, depression, and schizophrenia.

A review of the admission Minimum Data Set (MDS) assessment dated 07/10/18 indicated Resident #46 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for

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formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care.

On 11/27/18 at 9:44 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for coding Section A1500 and missed coding Resident #46 was determined as PASRR Level II on the admission MDS assessment dated 07/10/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #46 was determined as PASRR Level II. The SW stated she would need to submit a modification to the admission MDS assessment dated 07/10/18 to indicate Resident #46 was determined as PASRR Level II.

On 11/27/18 at 10:12 AM an interview was conducted with the interim Director of Nursing (DON) who stated her expectation was that the admission MDS assessment dated 07/10/18 would have been accurately coded to reflect Resident #46 was determined as PASRR Level II. The DON stated it was her expectation that the Social Worker would submit a modification to the admission MDS assessment dated 07/10/18 to indicate Resident #46 was determined as PASRR Level II.

On 11/27/18 at 1:05 PM an interview was conducted with the Administrator who stated her expectation was that the admission MDS assessment dated 07/10/18 would have been accurately coded to indicate Resident #46 was PASRR Level II. The Administrator stated her expectation was that the Social Worker would

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submit a modification to the admission MDS assessment dated 07/10/18 to indicate Resident #46 was PASRR Level II.

On 11/28/18 at 3:10 PM an interview was conducted with the MDS Coordinator who stated the admission MDS assessment dated 07/10/18 should have been coded by the SW to reflect Resident #46 was determined as PASRR Level II.

4. Resident #8 was admitted to the facility on 12/04/17 with a diagnosis of depression.

A review of the significant change Minimum Data Set (MDS) assessment dated 08/24/18 indicated Resident #8 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. Review of the resident's record noted Resident #8 had a PASRR Level II Determination Notification made on 03/04/16.

On 11/27/18 at 12:20 PM an interview was conducted with the Social Worker (SW) who stated she was responsible for coding Section A1500 and missed coding Resident #8 PASRR Level II on the significant change MDS dated 08/24/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #8 was determined as PASRR Level II. The SW stated she would need to submit a modification to the significant change MDS assessment dated 08/24/18 to indicate Resident

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#8 was determined as PASRR Level II.

On 11/28/18 at 12:33 PM an interview was conducted with the interim Director of Nursing (DON) who stated her expectation was that the significant change assessment dated 08/24/18 would have been accurately coded to reflect Resident #8 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the significant change assessment dated 08/24/18 to indicate Resident #8 was determined as PASRR Level II.

On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the significant change assessment dated 08/24/18 should have been coded by the SW to reflect Resident #8 was PASRR Level II.

5. Resident #45 was admitted to the facility on 03/11/13 with diagnoses of anxiety and depression.

A review of the annual MDS assessment dated 09/26/18 indicated Resident #45 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. Review of the resident's record noted Resident #45 had a PASRR Level II Determination Notification made on 01/29/13.

On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding Section A1500 and missed

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coding Resident #45 PASRR Level II on the annual MDS dated 09/26/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #45 was determined as PASRR Level II. The SW stated she would need to submit a modification to the annual MDS assessment dated 09/26/18 to indicate Resident #45 was determined as PASRR Level II.

On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the annual assessment dated 09/26/18 would have been accurately coded to reflect Resident #45 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the annual assessment dated 09/26/18 to indicate Resident #45 was determined as PASRR Level II.

On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the annual assessment dated 09/26/18 should have been coded by the SW to reflect Resident #45 was PASRR Level II.

6. Resident #24 was admitted to the facility on 03/13/17 with diagnoses of depression and schizophrenia.

A review of the significant change MDS assessment dated 09/26/18 indicated Resident #24 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an

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individual's plan of care. Review of the resident's record noted Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.

On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding Section A1500 and missed coding Resident #24 PASRR Level II on the significant change MDS dated 09/26/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #24 was determined as PASRR Level II. The SW stated she would need to submit a modification to the significant change MDS assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.

On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change assessment dated 09/26/18 would have been accurately coded to reflect Resident #24 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the significant change assessment dated 19/26/18 to indicate Resident #24 was determined as PASRR Level II.

On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the significant change assessment dated 09/26/18 should have been coded by the SW to reflect Resident #24 was PASRR Level II.

7. Resident #65 was admitted to the facility on 02/20/16 with diagnoses of depression and schizophrenia.

A review of the annual MDS assessment dated

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01/08/18 indicated Resident #65 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. Review of the resident's record noted Resident #65 had a PASRR Level II Determination Notification made on 03/09/16.

On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding Section A1500 and missed coding Resident #65 PASRR Level II on the annual MDS dated 01/08/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #65 was determined as PASRR Level II. The SW stated she would need to submit a modification to the annual MDS assessment dated 01/08/18 to indicate Resident #65 was determined as PASRR Level II.

On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the annual assessment dated 01/08/18 would have been accurately coded to reflect Resident #65 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the annual assessment dated 01/08/18 to indicate Resident #65 was determined as PASRR Level II.

On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the annual assessment dated 01/08/18 should have been coded by the SW to reflect Resident

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F 641	Continued From page 15 #65 was PASRR Level II.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		12/27/18

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F 656	Continued From page 16 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement care plan interventions for 1 of 1 residents reviewed for smoking (Resident #68), and failed to develop a care plan to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 7 of 9 residents (Resident #33, Resident #34, Resident #46, Resident #8, Resident #45, Resident #24, and Resident #65) identified as PASRR Level II. Findings included: 1. Resident #68 was admitted to the facility 04/20/18 with a readmission dated, 10/24/18, with diagnoses which included diabetes mellitus, heart failure, chronic obstructive pulmonary disease (COPD), insomnia, major depressive disorder, anxiety, visual loss of left eye, and tobacco use. A Significant Change Minimum Data Set (MDS), dated 08/06/18, indicated Resident #68's cognition was intact. The MDS indicated the resident required extensive assistance with two-person physical assistance for transfers and mobility. The MDS also indicated tobacco use was coded. A review of the care plan, dated 10/31/18, indicated Resident #68 was a smoker and	F 656	F656 – Develop / Implement Comprehensive Care Plan CFR(s) : 483.21(b)(1) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18 the Social Services Director immediately corrected the following residents' careplans to reflect their level II PASRR status: Resident #68; #33, #34; #46; #8; #45; #24; and #65. It's the facility's practice for the SSD to accurately code/submit resident data on each resident's PASSR status. SSD was not informed on the new PASRR Authorization codes and had misidentified PASRRs on the MDS. Because these PASRRs were miscoded the careplans were incorrect, which lead to the deficient practice. It's the facility's practice for all staff to be educated on the facility's smoking policy including policy and procedures on facilitating supervised smoking . One housekeeping staff member was not aware of all procedure(s) of facilitating supervised smoking. Because of their lack of full understanding of the process, this led to the deficient practice.	

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F 656	Continued From page 17 interventions included: she required a smoking apron and supervision while smoking. A review of a nursing progress note in the medical record of Resident #68, dated 11/8/2018, indicated reports of Resident #68 smoking in designated area unsafely. The resident was placed on supervised smoke times until a new smoke evaluation was obtained. A review of the Smoking Safety Screen, dated 11/08/18, revealed Resident #68 had cognitive loss, visual acuity deficits, and manual dexterity problems. The safety screen further revealed the resident wore a smoking apron as adaptive equipment and that supervision of the resident was required. The screen indicated that the plan of care was used to assure the resident was safe while smoking. Observations of Resident #68 were made in the smoking area from 11/27/18 to 11/28/18 and revealed that Resident #68 was not wearing the smoking apron one time and was observed smoking unsupervised two times. On 11/29/18 at 10:23 AM an interview was conducted with the MDS Coordinator. She indicated that the smoking care plan should have been followed for Resident #68 with constant supervision and a smoking apron when smoking. On 11/29/18 at 01:25 PM an interview was conducted with the Director of Nursing (DON). She revealed that her expectation was that the care plan for smoking should have been followed for Resident #68 with constant supervision and a smoking apron when smoking.	F 656	(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 11/28/18 the Services Director audited 100% of the careplans for PASRR corrections if needed. All careplans were correct and up to date as of this date. On 12/20/18 the Administrator and DON audited all care plans of residents who smoke and updated / corrected any and all necessary care plans at that time. On 11/28/18 the Administrator educated staff on Resident #68's smoking careplan interventions and expectations of following the careplan. In addition, she educated the staff on expectations of staff while facilitating supervised smoking with the residents on this date. On 12/19/18 the administrator educated the IDT team and charge nurses about the importance of creating, implementing and follow through of each resident's care plan per it's interventions and goals. On 11/30/18 the Administrator created and implemented a Supervised Smoking binder that outlined the following: 1) residents who needed to be supervised 2) any adaptive equipment that was to be used per resident 3) facility smoking policy and procedures 4) facility smoking agreements 5) information on how to properly and safely use smoking aprons, fire blankets and extinguishers. On 11/30/18 and on 12/5/18 the Administrator held in services to educate staff on this binder and how to utilize it. (3) The monitoring procedure to ensure that the plan of correction is effective and	

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F 656	Continued From page 18 On 11/29/18 at 01:30 PM the administrator revealed that her expectation was that the smoking care plan should have been followed for Resident #68 with constant supervision and a smoking apron when smoking. 2. Resident #33 was admitted to the facility on 05/24/16 with diagnoses including depression. A review of PASRR Level II determination indicated Resident #33 was determined as PASRR Level II. A review of a care plan with an initiation date of 05/27/16 with next review date of 01/18/19 revealed there was no comprehensive care plan with measurable goals and identified care plan interventions implemented for PASRR Level II for Resident #33. On 11/27/18 at 9:17 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a care plan for PASRR Level II for Resident #33 with measurable goals and interventions. The SW stated she was unaware that Resident #33 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #33. On 11/27/18 at 10:09 AM an interview was conducted with the interim Director of Nursing (DON) who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #33 with measurable goals and interventions. The DON stated her expectation was that the SW would create a	F 656	that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Beginning 12/20/18, the Administrator or designee will begin auditing the supervised smoking times to ensure residents careplans are being followed by staff per its interventions: three times per week for four weeks; then twice a week for four weeks, then once a week for four weeks. The Administrator or designee will also auditing careplans to ensure smoking careplans are current and being facilitated as such. Beginning 12/24/18, MDS Coordinator or Administrator will conduct random audit of no less than 5 care plans to ensure PASRR status is correctly reflected once weekly for 4 weeks, then twice a month for one month, then once a month for one month. Effective 12/27/18, audit findings of the care plan and smoking audits will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. (4) The title of the person responsible for implementing the acceptable plan of	

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F 656	Continued From page 19 comprehensive care plan for PASRR Level II for Resident #33. On 11/27/18 at 12:58 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #33 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #33. 3. Resident #34 was admitted to the facility on 04/20/18 with diagnoses including depression. A review of PASRR Level II determination indicated Resident #34 was determined as PASRR Level II. A review of a care plan with an initiation date of 04/23/18 with next review date of 01/8/19 revealed there was no comprehensive care plan with measurable goals and identified care plan interventions implemented for PASRR Level II for Resident #34. On 11/27/18 at 8:58 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a care plan for PASRR Level II for Resident #34 with measurable goals and interventions. The SW stated she was unaware that Resident #34 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #34. On 11/27/18 at 10:05 AM an interview was	F 656	correction: The individual responsible for implementing the credible plan of correction is the Administrator.	

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conducted with the interim Director of Nursing (DON) who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #34 with measurable goals and interventions. The DON stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #34.

On 11/27/18 at 1:06 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #34 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #34.

4. Resident #46 was admitted to the facility on 07/03/18 with diagnoses including anxiety disorder, depression, and schizophrenia.

A review of PASRR Level II determination indicated Resident #46 was determined as PASRR Level II.

A review of a care plan with an initiation date of 07/03/18 with next review date of 01/13/19 revealed there was no comprehensive care plan with measurable goals and identified care plan interventions implemented for PASRR Level II for Resident #46.

On 11/27/18 at 9:44 AM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a comprehensive care plan for PASRR Level II for Resident #46 with measurable goals and interventions. The SW stated she was unaware

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that Resident #46 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #46.

On 11/27/18 at 10:12 AM an interview was conducted with the interim Director of Nursing (DON) who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #46 with measurable goals and interventions. The DON stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #46.

On 11/27/18 at 1:05 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #46 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #46.

5. Resident #8 was admitted to the facility on 12/04/17 with diagnoses including depression.

A review of the PASRR Level II determination indicated Resident #8 was determined as PASRR Level II. Review of the resident's record noted Resident #8 had a PASRR Level II Determination Notification made on 03/04/16.

A review of the care plan dated 09/06/18 revealed there was no comprehensive care plan with measureable goals and identified care plan interventions implemented for PASRR Level II for

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Resident #8.

On 11/27/18 at 12:20 PM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a care plan for PASRR Level II Resident #8 with measurable goals and interventions. The SW stated she was unaware that Resident #8 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #8.

On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #8 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #8.

6. Resident #24 was admitted to the facility on 03/13/17 with diagnoses including depression and schizophrenia.

A review of the PASRR Level II determination indicated Resident #24 was determined as PASRR Level II. Review of the resident's record noted Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.

A review of the care plan dated 09/28/18 revealed there was no comprehensive care plan with measureable goals and identified care plan interventions implemented for PASRR Level II for Resident #24.

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On 11/27/18 at 12:20 PM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a care plan for PASRR Level II Resident #24 with measurable goals and interventions. The SW stated she was unaware that Resident #24 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #24.

On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #24 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #24.

7. Resident #45 was admitted to the facility 03/11/13 with diagnoses including depression and anxiety.

A review of the PASRR Level II determination indicated Resident #45 was determined as PASRR Level II. Review of the resident's record noted Resident #45 had a PASRR Level II Determination Notification made on 01/29/13.

A review of the care plan dated 10/17/18 revealed there was no comprehensive care plan with measureable goals and identified care plan interventions implemented for PASRR Level II for Resident #45.

On 11/27/18 at 12:20 PM an interview was conducted with the Social Worker (SW) who

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stated she was responsible for creating a care plan for PASRR Level II Resident #45 with measurable goals and interventions. The SW stated she was unaware that Resident #45 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #45.

On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #45 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #45.

8. Resident #65 was admitted to the facility 02/20/16 with diagnoses including depression and schizophrenia.

A review of the PASRR Level II determination indicated Resident #65 was determined as PASRR Level II. Review of the resident's record noted Resident #65 had a PASRR Level II Determination Notification made on 03/09/13.

A review of the care plan dated 10/17/18 revealed there was no comprehensive care plan with measureable goals and identified care plan interventions implemented for PASRR Level II for Resident #65.

On 11/27/18 at 12:20 PM an interview was conducted with the Social Worker (SW) who stated she was responsible for creating a care plan for PASRR Level II Resident #65 with

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F 656	Continued From page 25 measurable goals and interventions. The SW stated she was unaware that Resident #65 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #65. On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #65 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #65.	F 656		
F 689 SS=D	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 §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 and resident interviews, the facility failed to provide continuous supervision and a smoking apron for safe smoking for 1 of 1 residents reviewed for supervised smoking (Resident #68). The findings included: A review of the facility's undated smoking policy	F 689	F689 - Free of Accident Hazards / Supervision / Devices CFR(s): 483.25(d)(1)(2) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18, the facility Administrator, ensured that resident #68 had a smoking	12/27/18

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and procedure included that any resident that required supervision or had any smoking restrictions would only be allowed to smoke under direct supervision of staff and that all smoking adaptive/safety equipment, if care planned as such, must be used while smoking.

Resident #68 was admitted to the facility 04/20/18 with a readmission dated, 10/24/18, with diagnoses which included diabetes mellitus, heart failure, chronic obstructive pulmonary disease (COPD), insomnia, major depressive disorder, anxiety, visual loss of left eye, and tobacco use.

A Significant Change Minimum Data Set (MDS), dated 08/06/18, indicated Resident #68's cognition was intact. The MDS also indicated tobacco use was coded.

A review of the care plan, dated 10/31/18, indicated Resident #68 was a smoker and interventions in place included: required a smoking apron and supervision while smoking.

A review of a nursing progress note in the medical record of Resident #68, dated 11/08/2018, indicated the resident was smoking in designated area unsafely. The resident was placed on supervised smoke times until a new smoke evaluation was obtained.

A review of the Smoking Safety Screen, dated 11/08/18, revealed Resident #68 had cognitive loss, visual acuity deficits, and manual dexterity problems. The safety screen further revealed the resident wore a smoking apron as adaptive equipment and that supervision of the resident was required. The screen indicated that the plan of care was used to assure the resident was safe

apron to use during smoke times.
Additionally, on 11/28/18, the DON and Administrator completed in-service training with staff regarding the supervised smokers process to ensure that Resident #68 only smoked while supervised per care plan.
It's the facility's practice to abide by all supervised smoking guidelines including providing continuous supervision and to provide any adaptive equipment needed. Some staff were not aware of the need to provide continuous 1:1 smoking for the supervised smokers and the need for the apron for resident #68. Because of this lack of knowledge, this led to the deficient practice.

(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
On 11/28/18, the DON and Administrator completed in-service training with staff regarding the supervised smokers process. This training was repeated at the facility Staff meeting that occurred on 12/6/18.

To ensure the safety of all supervised smokers the following measure were taken: 1) additional smoking aprons were purchased and placed in the smoking area by the Administrator on 11/28/18, 2) beginning on 11/28/18 , all staff be educated upon hire as to the smoking policy/process, 3) smoking manuals were created by the administrator that outline the smoking policy, a list of supervised and non-supervised smokers, any

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F 689	Continued From page 27 while smoking. An interview was conducted with Resident #68 on 11/26/18 at 03:26 PM. She indicated that she was on a smoking restriction because she had a half of a cigarette lit and dropped it. She further indicated that she was supervised for a month until the nurse manager reassessed her. She stated that staff kept the cigarettes and lighter behind a door at the nurses' desk. She further stated that a staff member had one lighter and lit the cigarettes and that the smoking times were 9:30 AM, 1:00 PM, 4:00 PM, and 8:00 PM. She also stated that she removed her oxygen when she went outside to smoke and that ash trays were provided. She further revealed that she had no accidents or burns from smoking. On 11/27/18 a continuous observation was made from 04:17 PM to 04:19 PM, Resident #68 was observed holding her cigarette while smoking in the designated smoking area without an apron. Further observation revealed the resident did not burn herself. Further observation indicated Smoking Supervisor #1 left the designated smoking area and was out of the line of sight for Resident #68 for two (2) minutes to get another cigarette for another resident. On 11/28/18 from 09:34 AM to 9:36 AM, Resident #68 was observed being brought out to the smoking area by Smoking Supervisor #2. Smoking Supervisor #2 placed the smoking apron on Resident #68. Resident #68 started smoking a cigarette lit by Supervisor #2. Further observation revealed that Smoking Supervisor #2 left the smoking area at 9:35 AM and was out of the line of sight for Resident #68 until she returned to the smoking area at 9:36 AM with	F 689	adaptive equipment that the smoker requires, and how to use the smoking aprons and how to use the fire blanket. These manuals were placed on each unit on 11/30/18 by the Administrator. Staff were educated about this process and manuals at the “All Staff” Meetings held 12-6-18. The Social Services Director will be responsible for updating and replacing the list of smokers in each book and updating the care plan of resident as changes occur. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Beginning 12/27/18, the Social Services Director will audit supervised smokers on random shifts, the supervised smoking manual and the care plans three times a week for four weeks, then once a week for 4 weeks, then once a quarter times one. Any issues noted will be corrected immediately at that time. The Social Services Director will report on these audits to the QAPI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will	

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F 689	Continued From page 28 more smoking materials. Throughout the observation, Resident #68 held the lit cigarette. On 11/29/18 at 08:46 AM an interview was conducted with Smoking Supervisor #2. She stated that she took Resident #68 out to the smoking area at 9:30 AM every day and was told a few days prior that Resident #68 had to be supervised and watched. She revealed that she was not aware of the smoking aprons regarding which residents needed to wear it. She further revealed that she did not think Resident #68 needed the smoking apron. She did not indicate the reason that she left Resident #68 unsupervised at the designated smoking area on 11/28/18 for 1 minute, nor did she indicate where to find the information regarding which residents required a smoking apron during supervised smoking. On 11/29/18 at 09:03 AM an interview was conducted with the Smoking Supervisor #1. She indicated that she took Resident #68 out to smoke twice a week; that Resident #68 had no issues with smoking; she provided the cigarettes and lighter for her and lit her cigarettes for her. She stated that Resident #68 was supposed to be supervised because she was weaker when she returned from the hospital and dropped her cigarette once or twice. She further stated that supervised meant someone had to be with Resident #68 at all times. She revealed that Resident #68 did not have to wear a smoking apron and that one time she was care planned for smoking. She further revealed that, to her knowledge, another resident was the only one who had to wear an apron. She did not indicate the reason that she left Resident #68 unsupervised at the designated smoking area on	F 689	review, discuss, and implement any necessary changes as indicated. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Social Services Director.	

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11/27/18 for 2 minutes, nor did she indicate where to find the information regarding which residents required a smoking apron during supervised smoking.

On 11/29/18 at 10:04 AM an interview was conducted with the North Hall Nursing Unit Manager. She stated that Resident #68 was a supervised smoker and was not safe to light cigarettes. She further stated that Resident #68 was previously an unsupervised smoker; however, she fell asleep and dropped the cigarette and it rolled on her smoking apron to the ground. She indicated that the resident was deemed a supervised smoker on 11/08/18. She further indicated that Resident #68 was supposed to wear the smoking apron and whoever took her out to smoke, had to light the cigarette. She further revealed that she had to make sure residents were safe smokers before they were deemed unsupervised. She did not indicate how staff knew to meet specific needs of supervised smoking residents.

On 11/29/18 at 1:25 PM an interview was conducted with the former interim Director of Nursing (DON). She indicated that nursing staff kept a running list of supervised and unsupervised residents and which residents wore smoking aprons and that the list was hanging at the nursing station for Smoking Supervisors to access. At the time of the interview, the former interim Director of Nursing went to both nurses' stations and was unable to locate the list of supervised and unsupervised residents with the names of residents that required a smoking apron. The former interim Director of Nursing could not explain why the list of supervised and unsupervised residents was not posted at the

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F 689	Continued From page 30 nurses' station and revealed that her expectation was to communicate effectively to staff regarding who are were supervised and unsupervised smokers and ensure proper adaptive equipment (smoking apron) was followed. On 11/29/18 at 1:30 PM an interview was conducted with the Administrator. She stated she assumed the smoking supervisors followed the smoking policy for supervised and unsupervised smokers. She indicated that her expectation was that the smoking supervisors assigned to the smoking area would not leave the residents, who were deemed unsafe to smoke, unsupervised; would light the residents' cigarettes; and place a smoking apron on all residents who required a smoking apron.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		12/27/18

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F 756	Continued From page 31 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of pharmacy recommendations and staff interview the facility failed to acknowledge or respond to 43 pharmacy recommendations from September 2018 and October 2018 which affected 2 of 5 sampled residents reviewed for medications. (Residents #59 and #81) The findings included: On 11/28/18 at 2:12 PM the former interim Director of Nursing (that served in the role from September-11/26/18) stated, until asked by the surveyor, she was not aware of the system to address recommendations by the consultant pharmacist. The former interim Director of Nursing stated she called the consultant pharmacist (after the monthly drug reviews were	F 756	F756 □ Drug Regimen Review , Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18, the Inter Disciplinary Team (IDT), along with the respective resident□s attending physician, reviewed the pharmacy recommendations for the months of September 2018 and October 2018 for residents #59 and #81 and implemented those the providers were in agreeance with. It□s the facility's practice for the DON to provide the attending physician with the pharmacy recommendation monthly or as	

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requested by the surveyor) to discuss the process to obtain the reviews. After the interview on 11/28/18, the pharmacy recommendations for September 2018 and October 2018 were printed by the former interim Director of Nursing. These included 24 recommendations for the month of September 2018 and 19 recommendations for the month of October 2018. Of these 43 recommendations, three were specific to 2 of 5 sampled residents with medications reviewed and included the following:
a. On 10/22/18 the consultant pharmacist noted on 03/20/18 Resident #59 "was started on Remeron for appetite stimulation. At the time, her weight was 129 pounds. Her ideal body weight is listed as 120 pounds. Her current weight is recorded as 138 pounds. She also receives Lexapro." The consultant pharmacist asked, "Please evaluate continued need for Remeron."
b. On 9/23/18 the consultant pharmacist noted that Resident #81 "receives Atorvastatin but does not have a current lipid evaluation documented in the resident record within the previous 12 months." The consultant pharmacist asked, "Please consider monitoring a fasting lipid panel on the next convenient lab day and annually thereafter."
On 10/26/18 the consultant pharmacist noted that Resident #81 "was started on Mobic 15 milligrams every morning. On 08/16/18, her serum creatinine was 1.22." The consultant pharmacist asked, "Please consider checking a current creatinine."

On 11/28/18 at 3:55 PM the consultant pharmacist stated the facility had several changes in the Director of Nursing position in recent months. The consultant pharmacist stated

needed for appropriate follow up. The interim DON was not aware of her role in this process. Due to this the pharmacy recommendations did not get passed onto the physician which lead to the deficient practice.

(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
To ensure that all residents pharmacy recommendations for the month of September 2018 and October 2018 were not missed, the DON along with the provider reviewed 100% of the recommendations and implemented all orders that provider agreed with into the resident□s EMR.

Consultant pharmacist educated the DON as to the importance and processes involved with addressing the pharmacist recommendations in a timely manner on 12/20/18. The DON educated the nursing management team to the new process of addressing pharmacy recommendations on 12/2/18. This process is 1) the consultant pharmacist will email the recommendations to the DON monthly, 2) the DON or designee will met with the provider to review the monthly recommendations within 5 days of receiving them via email, the DON or designee with then process all provider approved recommendations into the individual resident□s MAR, 3) the DON or designee will then ensure the pharmacy recommendations are scanned into the individual resident□s EMR, 4) the printed

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F 756	Continued From page 33 that prior to September 2018 the former Director of Nursing was familiar with the system to obtain the monthly drug review recommendations. The consultant pharmacist stated she sent an email noting the September 2018 drug reviews were ready for review to the former Director of Nursing, not the former interim Director of Nursing. The consultant pharmacist stated she sent an email to the administrator on 10/31/18 to inform her the drug reviews were ready for review. The consultant pharmacist stated she spoke to the former interim Director of Nursing around Thanksgiving to explain how to access the electronic drug reviews via the pharmacy system and sent an email on 11/18/18 to let her know the electronic drug reviews were completed. The consultant pharmacist stated on 11/20/18 she sent the November drug reviews as an attachment to the administrator because she wasn't sure the recommendations had been accessed by the former interim Director of Nursing. The consultant pharmacist stated she didn't realize until 11/28/18 that the former interim Director of Nursing didn't have access to the electronic drug reviews or that reviews from September 2018 and October 2018 had not been printed for review. The consultant pharmacist stated she had planned to address the system to obtain pharmacy reviews when she was back in the building again in December 2018. On 11/28/18 at 4:20 PM the administrator stated she began working at the facility August 2018. The administrator stated up until 11/20/18 she had been asking staff about the pharmacy reports and staff told her they didn't receive a pharmacy report. The administrator explained she didn't think staff understood she was talking about the monthly drug reviews when she was asking about	F 756	copies of the pharmacy recommendations will then be placed into a notebook in the DON office. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Beginning within the range of 12/31/18 to 1/10/19, the DON and Administrator will audit all pharmacy recommendations to ensure they are addressed and processed in a timely manner monthly times 4 month, every other month times two months then quarterly times two. The DON will report on these audits to the QAPI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Director of Nursing.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 756	Continued From page 34 the pharmacy reports. The administrator stated she had not seen monthly drug reviews until she received the email (with individual pharmacy reviews attached) on 11/20/18 from the consultant pharmacist. The administrator stated she printed the November pharmacy reviews and handed them to the former interim Director of Nursing to review. The administrator stated she expected monthly drug reviews to be addressed in a timely manner and didn't realize until 11/28/18 that the drug reviews for September 2018 and October 2018 had not been accessed or addressed. On 11/29/18 at 12:00 PM the Family Nurse Practitioner (FNP) stated upon arrival to the facility that morning she was informed the monthly drug reviews for September 2018 and October 2018 had not been printed for review. The FNP stated the system had always worked smoothly up until recent nursing management changes. The FNP stated she depended on staff to alert her when the drug reviews were completed and ready for review and typically addressed the reviews within 30 days. The specifics of the drug reviews for September 2018 and October 2018 affecting Resident #59 and Resident #81 were reviewed with the FNP and the FNP stated the delay in addressing pharmacy reviews did not cause any harm to the residents.	F 756		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming	F 810		12/27/18

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F 810	Continued From page 35 meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide a sippy cup to two of two residents reviewed for adaptive devices. (Residents #20 and #47). The findings included: 1. Resident #20 was admitted to the facility 09/21/13 with diagnoses which included: hypertension, non-Alzheimer's dementia, anxiety, depression, chronic obstructive pulmonary disease, hypothyroidism, failure to thrive, heart disease, vitamin D deficiency, and weight loss. The care plan for Resident #20 was last updated 09/24/18 and included the potential for weight fluctuation related to variable oral intake, bland diet and vision loss. Resident #20 was on a mechanically altered diet of ground meats, was an extensive assist for meals, and ate in the assisted dining room. Observations of Resident #20 at 2 of 4 meals noted a sippy cup was not provided at the meal. These observations included: a. On 11/26/18 at 12:46 PM Resident #20 was observed eating lunch in the assisted dining room. The tray card for Resident #20 noted a sippy cup should be provided with the meal. There were 2, 4 ounce juice containers and a mighty shake on the tray and no cups or sippy cup. The resident's hands were shaky and she spilled juice on the clothing protector covering her shirt. Resident #20 had 19 dime sized spills on the clothing protector at the end of the meal.	F 810	F810 – Assistive Devices – Eating Equipment / Utensils CFR(s) : 483.60(g) (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18, the Dietary Director delivered sippy cups to resident #20 and Resident #47 at lunch. On 11/28/18, the Dietary Director and the regional nurse consultant reviewed adaptive equipment orders for resident #20 and #47 and modified their tray cards to reflect orders for adaptive equipment (specifically, sippy cups) to ensure they delivered with trays at meal time thereafter. IDT team reviewed diet/equipment orders for residents #20 and #47 to ensure those identified residents had needed assisted devices, sippy cups, ordered and ensured they were printed on their tray cards. It's the facility's practice for all tray cards and physician orders to match accordingly. Additionally, it is the facility's practice for dietary staff to read the tray cards thoroughly and ensure all tray card instructions are followed including adding adaptive equipment on the trays before they are served. The dietary staff did not follow the tray card instructions thus no sippy cups were present on the tray and this lead to the deficient practice. (2) The procedure for implementing the	

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F 810	Continued From page 36 b. On 11/28/18 at 12:51 PM Resident #20 was observed eating lunch in the assisted dining room. Resident #20 was being assisted with eating ground chicken, corn, cauliflower, a roll, yogurt, mighty shake, and 2, 4 ounce grape juices. There was no sippy cup on the tray. At the time of the observation nursing assistant (NA) #3 stated the resident does use a sippy cup if one is on the tray, but otherwise the staff hold the cup for the resident. The tray card for Resident #20 noted a sippy cup should be provided with the meal. c. On 11/28/18 at 4:20 PM Resident #20 was observed eating dinner in the assisted dining room. Resident #20 had a sippy cup and was able to drink juice independently. The tray card for Resident #20 noted a sippy cup should be provided with the meal. d. On 11/29/18 at 8:46 AM Resident #20 was observed eating breakfast in the assisted dining room. Resident #20 was being assisted with eating 2 boiled eggs, waffle, oatmeal, yogurt, mighty shake and 2, 4 ounce juices. Resident #20 was provided juice in a sippy cup and was able to drink without assistance. On 11/28/18 at 3:08 PM the Director of Therapy stated the need for the sippy cup was evaluated by therapy and entered into the communication book for the doctor to order. Review of the medical record noted on 11/19/18 the physician ordered the sippy cup for Resident #20. On 11/28/18 at 2:45 PM the Food Service	F 810	acceptable plan of correction for the specific deficiency cited: On 11/28/18, the IDT (Regional nurse Consultant; DON; MDS Coordinator; Dietary Director; and Regional MDS Coordinator) completed a 100% audit of all residents' dietary orders and their respective tray cards to ensure they matched and that the tray cards had all assistive devices clearly printed on their tray cards. Any issues identified during this audit were immediately corrected by the DON on 11/28/18. On 12/18.18 Administrator conducted in-service education with Dietary Manager (DM) and Nurse administration team on the importance of checking orders daily for any assisted devices ordered to ensure they are pulled over into the tray card system. DM conducted in-service education on 12/18/18 and 12/19/18 with dietary staff regarding checking the tray card thoroughly every meal to ensure no assisted devices are left off of trays. Nurse admin conducted in-service education with clinical staff emphasizing that they read tray card when delivering trays on the hall to ensure all devices are present on the tray at time of delivery. Administrator educated Risk IDT to ensure ordered assisted devices are discussed weekly in Risk Meeting to confirm none are missed on the tray card system. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains	

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F 810	Continued From page 37 Director stated she expected the kitchen staff to send adaptive equipment on the resident's food tray as ordered by the physician. The Food Service Director stated she did not know why the sippy cup had not been sent at lunch on 11/26/18 and 11/28/18. On 11/28/18 at 4:34 PM the Director of Nursing stated her expectation was for the resident to receive the adaptive equipment ordered by the physician. On 11/28/18 at 5:19 PM the Administrator stated her expectation was for the adaptive equipment to be provided to the resident in accordance with the physician orders. 2. Resident #47 was admitted to the facility 03/13/13 with diagnoses which included: non-Alzheimer's dementia, Parkinson's, anxiety, depression, feeding difficulties, dysphagia, vitamin D deficiency, and gastroesophageal reflux. The care plan for Resident #47 was last updated 09/21/18 and included the potential for weight fluctuation related to mechanically altered diet. Resident #47 was on a mechanically altered diet of ground meats, required supervision for meals, and ate in the assisted dining room. Observations of Resident #47 at 2 of 4 meals noted a sippy cup was not provided at the meal. These observations included: a. On 11/26/18 at 12:46 PM Resident #47 was observed eating lunch in the assisted dining room. The tray card for Resident #47 noted a sippy cup should be provided with the meal.	F 810	corrected and / or in compliance with regulatory requirements: Beginning 12/19/18, the dietary manager will audit tray line across varying meal times (breakfast, lunch, dinner) to validate that assisted devices are present on the required trays three times a week x four weeks; then twice a week x four weeks; then once a week x four weeks. Any issues noted during these audits will be immediately corrected by the Dietary Manager at that time. Starting 12/27/18, audit findings for adaptive equipment will be reported by the Dietary Manager to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes needed. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Certified Dietary Manager.	

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F 810	Continued From page 38	F 810		

There were 2, 4 ounce juice containers on the tray and no cups.

b. On 11/28/18 at 12:58 PM Resident #47 was observed eating lunch in the assisted dining room. Resident #47 was being supervised eating ground chicken, corn, cauliflower, roll, and 2, 4 ounce grape juices. No sippy cup was on the tray. A nursing assistant (NA) stated she had never seen the resident use a sippy cup. The tray card for Resident #47 noted a sippy cup should be provided with the meal.

c. On 11/28/18 at 4:22 PM Resident #47 was observed eating dinner in the assisted dining room. Resident #47 had a sippy cup and was able to drink juice independently. The tray card for Resident #47 noted a sippy cup should be provided with the meal.

d. On 11/29/18 at 8:46 AM Resident #47 was observed eating breakfast in the assisted dining room. Resident #47 was being supervised with eating 2 boiled eggs, toast, waffle, oatmeal, ensure clear and 2, 4 ounce juices. Resident #47 was provided juice in a sippy cup and was able to drink without assistance.

On 11/28/18 at 3:08 PM the Director of Therapy stated the need for the sippy cup was evaluated by therapy and entered into the communication book for the doctor to review.

On 11/28/18 at 2:45 PM the Food Service Director stated she expected the kitchen staff to send adaptive equipment on the resident's food tray as indicated on the tray card. The Food Service Director stated she did not know why the sippy cup had not been sent at lunch on 11/26/18

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F 810	Continued From page 39 and 11/28/18. On 11/28/18 at 4:34 PM the Director of Nursing stated her expectation was for the resident to receive the adaptive equipment as indicated on the tray card. On 11/28/18 at 5:19 PM the Administrator stated her expectation was for the adaptive equipment to be provided to the resident in accordance with the tray card.	F 810		