STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345491	A. BUILDING _____ B. WING _____	C 02/15/2019

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CROATAN RIDGE NURSING AND REHABILITATION CENTER	210 FOXHALL ROAD NEWPORT, NC 28570

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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/11/19 through 02/15/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ODT511.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/11/19 to conduct a recert/complaint survey and exited on 02/14/19. Additional information were obtained on 02/15/19. Therefore, the exit date was changed to 02/15/19.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		3/15/19

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

Electronically Signed | 03/09/2019

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview the facility failed to provide showers as scheduled for 1 of 1 resident sampled for choices. (Resident #7). The findings included: Resident #7 was admitted to the facility on 11/01/2018 with diagnoses including Paraplegia, and Multiple Sclerosis. The Quarterly Minimum Data Set dated 02/07/2018 had Resident #7 coded as cognitively impaired and coded as needing total dependence with dressing eating, toilet use, and personal hygiene. Comprehensive care plan dated 02/05/2019 had a focus of Assisted Daily Living due to Multiple Sclerosis had measured goals and interventions. Reviewed shower schedule for resident #7. The shower days are Mondays and Thursday's evening. Reviewed shower documentation from 1/10/2019 to 2/11/2019 and Resident #7 missed 7 out of the 10 showers that were scheduled. The shower days that were missed after the concern/grievance were 1/17, 1/21, 1/24, 1/31/2019, and 2/4, 2/7, 2/11/2019. Reviewed facility concern/grievance form dated 1/10/2019 for Resident #7 with a	F 561	Resident #7 was offered and given a shower on 2/14/2019 by the assigned nursing assistant (NA). 100% audits of showers for all Residents x7 days was completed on 2/12/2019 by the Facility Consultant to identify any Resident who was not offered a shower during the review period or who is not documented as refusing a shower. All area of concerns were immediately addressed by the assigned hall nurse to include offering and providing resident with a shower or documenting Resident refusal of the shower with notification of the Resident Representative (RR) of refusal if indicated. All areas of concern were addressed by the Quality Assurance Nurse (QA), assigned hall nurse, and Nurse Supervisor to include providing showers per resident preference and/or documentation of refusal of care. 100% Resident Preference Questionnaire was initiated by the Administrator on 3/5/2019 with all alert and oriented resident to include resident #7 in regards to shower preference to include: 1. Are you able to choose a bath or shower? 2. Are you able to chose how often and what time you shower/bathe?	

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F 561	Continued From page 2 concern/grievance of needing shower to wash hair well. The steps taken was to provide Resident #7 a shower. During interview with Resident#7 at 02/14/2019 on 01:30 P.M., Resident #7 stated she wanted to have more showers than what is given to her and she had told them about it. During an interview with NA #1 on 02/14/2019 at 03:47 P.M., NA #1 stated she didn't remember working with Resident #7 on 02/04/2019 and couldn't remember why Resident #7 didn't received a shower that day. During an interview NA #3 on 02/13/2019 08:43 A.M., NA#3 stated they must do 2-3 showers during the shift but due to staffing call outs it is overwhelming to try to get the showers done. During an interview with NA #2 on 02/14/2019 03:49 P.M., NA #2 stated she never refused a shower when I care for her and she enjoys getting her hair washed. During an interview with the Nurse supervisor on 02/13/2019 03:36 P.M., the Nurse Supervisor stated that her expectation for staff are to give showers as scheduled, ask if they wanted showers, document if they refuse, and report to nurse if they refuse. During interview with Nurse #1 on 02/14/2019 at 01:53 P.M., Nurse #1 stated she was not aware that resident was missing showers and that she would get a report from the NA's stating if a resident has not had any. During an interview with the Interim Director of	F 561	Care plan/care guides, to include Resident #7, were updated by the Minimum Data Set Nurse (MDS) and Nurse Supervisor for Resident preferences identified during the audit to include shower preferences. 100% in-service was initiated on 1/29/2019 by the Staff Facilitator with all nurses and NA's in regards to Resident Preferences to include: (1) Residents have the right to make choices about aspects of life in the facility that are significant to the residents. This includes but not limited to choosing bath or shower preference, wake/sleep time preferences, meal preferences, activity preferences and religious preferences. (2) Staff should notify the assigned hall nurse or nurse supervisor when a resident voices a new preference so the facility can attempt to accommodate the preference. (3) Care plans must be updated with the Resident preferences. (4) Staff must attempt to honor resident preferences to include shower times and notify the Nurse supervisor if preferences cannot be honored for an reason. In-Services was completed 3/5/2019. All newly hired nurses and NA's will be in-serviced by the Staff Facilitator during orientation in regards to Resident Preferences. 100% in-service was initiated with all Nursing and CNA's by the Staff Facilitator on 1/29/2019 in regard to Resident Showers to include (1) Shower schedules (2) Nurses responsibility to ensure all	

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F 561	Continued From page 3 Nursing (DON) on 02/13/2019 at 11:03 A.M., the DON stated we recognized that there was a problem with showers and that residents were not being showered as scheduled. We have been educating staff to look at the shower schedules and make sure residents are asked for their shower preference, residents that are refusing showers are being document in computer by the NA's and residents that are scheduled to be showered receive their showers. The Interim DON also stated that her expectations are for staff to shower residents as scheduled. During an interview with the Administrator on 02/14/2019 at 04:42 P.M., the Administrator stated the resident has expressed wanting more showers and even though she is coded as cognitively impaired, she can hold a conversation with you and she knows what she wants. The Administrator also stated her expectations are for her staff to give showers according to the shower schedule unless the resident refuses.	F 561	Residents are offered and received a shower per the resident preference and/or according to facility protocol. (3) The NAs must attempt to complete all assigned showers daily and notify the hall nurse or nurse supervisor when resident refuses care/shower (4) Whenever a Resident refuses a shower, the NA must immediately notify the assigned hall nurse of Nurse Supervisor. The assigned hall nurse must attempt to encourage resident to obtain a shower. (5) Staff should attempt other alternatives to encourage compliance as indicated and document alternatives attempted along with resident response to alternatives attempted and notification of RR of refusal. (6)Updating care plan/care guides with resident preferences/refusals of care. (7) documentation in POC under 'type of bath" after each bed bath or shower. In-Service was completed 3/5/2019. All newly hired nurses and NAs will be in-serviced by the Staff Facilitator during orientation in regards to Resident Showers. 10% of assigned resident showers, to include Resident #7 and all shifts and weekends, will be reviewed 5 times a week for 2 weeks, weekly for 2 weeks, then monthly for one month by the nurse supervisor and the Quality Assurance (QA) nurse utilizing the Shower Audit Tool to ensure all Resident are offered/provided a shower per resident preference and/or facility protocol. Any identified areas of concern will be immediately addressed by the nurse	

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F 561	Continued From page 4	F 561	supervisor, assigned hall nurse, nursing assistants, and QA nurse to include providing resident care per preference, updating care plan/care guide of resident preference, notification of the Resident representative of care refusals and/or additional staff training. The DON will initial the Showers Audit Tool Weekly x4 weeks, then monthly for one month to ensure all areas of concern were addressed. 10% Resident Preference Questionnaire will be completed by the Social Worker and/or Activity Director with alert and oriented Residents weekly x4 weeks, then monthly x 1 month to ensure resident preferences to include showers is being honored appropriately, to include up dating care plan/care guide of resident preference as indicated. The DON will initial the Resident Preference Questionnaire weekly for 4 weeks, then monthly for one month to ensure all areas of concern were addressed. The Administrator will forward the results of the Shower Audit Tool and the Resident Preference Questionnaire to the Executive QI Committee monthly x 2 months. The Executive QI Committee will meet monthly x2 months and review the Showers Audit Tool and the Resident Preference Questionnaire to determine trends and / or issues that may need further interventions put onto place and to determine the need for further and/or frequency of monitoring.	

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F 602	Continued From page 5	F 602		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and police interview the facility failed to prevent medication diversion for 2 of 2 residents sampled for misappropriation of property (Resident #7 and Resident #60). The findings included: 1. Resident #7 was admitted to the facility on 11/01/2018 with diagnoses including Multiple Sclerosis. The quarterly Minimum Data Set dated 02/07/2018 had Resident #7 coded as moderately cognitively impaired and coded for scheduled pain medication. The comprehensive care plan dated 02/05/2019 had a focus of Pain due to Multiple Sclerosis. The care plan had measured goals and interventions including the administration of pain medication. The Medication Administration Record (MAR) for Resident #7 dated 12/2018 was reviewed and listed Percocet (narcotic pain reliever)5/325 milligrams(mg) to be administered twice a day. Further review of the December 2018 MAR did not reveal any missing documentation for	F 602	On 12/13/2018 100% audit of all current Residents Medication Administration Records (MARS) and Controlled Substance count sheets x 30 days was initiated by the Director of Nursing (DON) for any Resident who received controlled substances medications, to include Resident #7 and Resident #60 to ensure (1) MARs were completed by the nurse and/or medication aide and accurate for use of controlled substances (2) documentation was completed for all narcotic as needed medications (PRN), to include date/hour, medication/dosage, route, reason, nurse initials, results, response, and nurse initials and (3) documentation of administration of controlled substance was consistent with Controlled Substance Count Sheet without discrepancies. Audit was completed on 12/31/2018. All areas of concern were addressed by the DON during the audit. On 12/13/2018 100% audit of all pharmacy packing slips for controlled	3/15/19

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F 602	Continued From page 6 administration of medications for 12/2018. A review of the investigation summary signed by the Administrator, dated 12/13/2018 revealed a time line of events indicating Nurse #1 reported she was unable to refill Resident #7's Percocet reorder. There was only one pill left but pharmacy stated it was not time to refill medication prescription. A packing slip was found and showed on 11/22/18 a total of 60-50 mg Percocet was delivered for Resident #7. The hand-written count sheet was written for 30-50 mg Percocet tablets. A search was conducted for the missing 30 tablets of Percocet and the original count sheet and either could be found. An investigation was opened, and the police were called. Review of a police report dated 12/13/2018 for property missing (30 Percocet) belonging to Resident #7 indicated Newport Police Department received a call to go to Croatan Ridge due to possible narcotics "Percocet" being stolen from the facility. Upon arrival, the officer met with Administrator and was informed that medication was missing from inventory belonging to Resident #7. The Administrator stated there was missing paperwork that had the correct amount of medication and there was a Nurse (Nurse #3) suspected and would be suspended pending investigation. The police report concluded further investigation would be conducted through the Newport police department. During a telephone interview with the police officer (PO) in charge of the investigation on 2/15/2019 at 4:59 PM, the PO stated there were indeed missing medications and there was an investigation by the department but there was not enough proof to file charges against anyone	F 602	substances and pharmacy Return of Control Substance Forms was initiated by the DON to ensure there were no discrepancies in the Controlled Substance Count Sheets and that pharmacy received all medications per the Controlled Substance Return Form. All identified areas of concern were immediately addressed by the DON during the audit. The audit was completed by 12/31/2018. On 12/13/2018 the DON made the Medical Director, Pharmacy Consultant and Director of Pharmacy Clinical Service aware of possible drug diversion. On 12/13/2018 the DON sent a 24 hour report of diversion of resident drug to the Health Care Personnel Registry. On 12/13/2018. the DON notified the Police department and an investigation was initiated for possible drug diversion. The Police Department closed the investigation on 1/24/2019 with no charges filed. On 12/13/18 attempts were made to contact Nurse #3 without results. Nurse #3 was not scheduled to return to work till 12/15/2018. On 12/15/2018 contact was made with Nurse #3. Nurse #3 was drug screened and suspended pending investigation by the DON. On 12/23/2018, Nurse #3 was terminated by the DON and Administrator following	

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F 602	Continued From page 7 because there was no proof as to who could have taken them. The PO also stated the investigation was closed on January 24, 2019. During an interview with Nurse #1 on 02/14/2019 at 04:13 PM, Nurse #1 stated she was the nurse that brought the medication discrepancy to the former Director of Nursing (DON) and Administrator on 12/13/2018. Nurse #1 stated they were running low on Resident #7's Percocet's 5/325 on 12/13/2018, so a reorder of the medication was attempted but the pharmacy stated 60 tablets of the medication was just delivered on 11/22/2018 and it wasn't time for a refill. The count sheet dated 11/28/2018 had Percocet 5/325, 30 tablets handwritten in on the sheet. Nurse #1 noted the pharmacy usually sends a computer-generated sheet, so she reported the discrepancy. Nurse #1 also stated Resident #7 did not miss any scheduled medication and the medication count according to the sheet, was not off so that is why it wasn't noticed sooner. During an interview with the Administrator on 02/12/2019 at 02:56 PM, The Administrator stated on 12/13/2018 Nurse #1 reported to the former DON and herself that it was time to refill Resident #7's 50 mg of Percocet prescription. Nurse #1 was told by pharmacy that it wasn't time for a refill and should have had around two weeks left. The Administrator also stated there was a packing slip dated 11/22/2018 that listed a prescription of 60 Percocet 5/325 mg for Resident #7 and a handwritten order count sheet for Resident #7 dated 11/28/18 for 30 tablets of Percocet 5/325 mg was found with Nurse #3 as the first signature to sign out the medication. The Administrator stated the order count sheet is supposed to be	F 602	results of drug screen. On 2/15/2019 100% audit of all residents to include Resident #7 (Resident #60 was no longer at facility) were assessed for pain and/or an increase in behaviors by the Nurse Supervisor with no identified areas of concerns On 2/15/2019 100% questionnaires in regards to Pain were completed by the Social Worker / Activities Director with all alert and oriented Residents regarding pain control concerns. Questionnaires included: 1. When you re having pain, does our nurse provide pain medication? 2. Is your pain medication effective? There were 2 areas of concern that were addressed by the nurse Supervisor. On 2/15/2019 100% audit of all nurses and medication aides' license verification and HCPR was completed by the Payroll with no identified concerns. On 2/15/2019 the DEA was contacted by the Interim DON to verify notification of the possible drug diversion at the facility. Local DEA was unavailable until 2/19/2019. Interim DON attempted to followed up with DEA on 2/19/2019 with no response from EDA. Completion of notification to DEA by the Administrator on 2/28/2019. An in-service was initiated with all Nurses and medication aides on 2/14/2019 by QA nurse in regards to Controlled Substance Diversion to include: (1) what is drug	

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F 602	Continued From page 8 computer generated not hand written and it should have started at 60 tablets and not 30 tablets of the Percocet 5/325 mg tablets. The Administrator also stated Nurse #3 was drug tested and was asked why she hand written a new count sheet and she stated she didn't know and guessed the amount that was there and started a new sheet. The Administrator further stated Nurse #3 was suspended while the investigation was on-going and when the drug test came back as urine that was not human, Nurse #3 was terminated. A urine sample result for Nurse #3 dated 12/15/18 was reviewed and read: not consistent with normal human urine. Nurse #3 could not be reached for interview due to the disconnection of number provided by facility. The former Director of Nursing could not be reached for interview due to the disconnection of number provided by facility. During an interview with the Administrator on 02/14/19 at 04:42 PM, the Administrator stated the in-house investigation and the police investigation were completed and found the medications were missing but there were no charges filed due to lack of evidence. The Administrator also stated that Residents #7 did not miss any scheduled medications and her expectations were to assure medications for residents are not ever diverted or misappropriated. 2. Resident #60 was admitted to the facility on 11/21/2018 with diagnoses of End Stage Renal Disease. The admission Minimum Data Set dated	F 602	diversion, (2)signs of diversion, (3) following the chain of custody, (4) declining count sheets, (5) delivery manifest, (6) Controlled Substance Return Forms, (7) count of controlled substances between shifts, (8) reporting discrepancies in controlled substance count, and (9)documentation of narcotic administration. In-service was competed on 3/6/2019. All newly hired nursed and medication aides will be in-serviced during orientation by the staff facilitator in regards to controlled substance diversion. On 3/4/2019 an additional in-service was provided by the Pharmacy Consultant with nurses and medication aids in regards to Control Substance Diversion. Any nurse or medication aide who did not attend the Pharmacy Consultant in-service will be provided updated material and in-serviced by the Nurse Supervisor by 3/15/2019. On 2/19/2019 100% in-service was initiated by the Staff Facilitator with all nurses and medication aides in regards to Misappropriation to include diversion of resident medications. In-service completed by 2/25/2019. All newly hired nurses and medication aides will be in-serviced during orientation by the staff facilitator in regards to Misappropriating to include diversion of resident medications. In-Service was completed on 3/6/2019. All newly hired nurses and medication aides will be in-serviced during orientation by the Staff Facilitator in regards to Misappropriation to include diversion of resident	

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F 602	Continued From page 9 11/28/18 has resident coded as cognitively intact and having had used an as needed (PRN) pain medication during assessment period. The comprehensive care plan dated 11/25/2018 had a focus of Pain and had measurable goals and interventions including administering PRN pain medication. The Medication Administration Record for Resident #60 dated 11/2018 was reviewed and listed Percocet (narcotic pain reliever) 5/325 mg every 4 hours as needed for pain. During an interview with the Administrator on 02/12/2019 at 02:56 P.M., the Administrator stated during an audit on 12/13/2018, a packing slip dated 11/30/2018 listed a prescription of 15 Percocet 5/325 mg was delivered for Resident #60 but the order count sheet and the 15 Percocet 5/325 mg tablets were missing. The Administrator also stated a 24-hour report was filed, the Police Department was called, and an investigation was opened. The Administrator noted Nurse #3 was drug tested and suspended while the investigation was on-going and when the drug test came back as urine that was not human, Nurse #3 was terminated. The Administrator further stated that Resident #60 did not miss any medications. A urine sample result for Nurse #3 dated 12/15/18 was reviewed and read: not consistent with normal human urine. Nurse #3 could not be reached for interview due to the disconnection of number provided by facility. The former Director of Nursing could not be reached for interview due to the disconnection of	F 602	medications. 10% audit of MAR's and Controlled Substance Count Sheets will be completed by the Nursing Supervisor for any Resident receiving controlled substance medications covering all shifts and weekends to include Resident #7 and (Resident #60 no longer in facility) utilizing the Controlled Substance Audit Tool 3x per week for 4 weeks, weekly for 4 weeks, then monthly for 1 month to ensure (1) MAR's were completed by the nurse and/or medication aide and accurate for use of controlled substances (2) documentation was completed for all narcotic as needed medication (PRN), to include date/hour, medication/dosage, route, reason, nurse initials, results, response, and nurse initials, and (3) documentation of administration of controlled substance was consistent with Controlled Substance count Sheet without discrepancies. All areas of concern will be immediately addressed by the Nurse Supervisor for any identified areas of concern. DON will review and initial the Controlled Substance Audit Took weekly x 8 weeks then monthly x1 month to ensure all areas of concern were addressed. The QA will audit the 100% manifest sheets compared to the controlled substance count sheet 3 times a week x4 weeks, weekly for 4 weeks, then monthly for 1 month to ensure controlled substance count sheet matches the manifest sheet from pharmacy. All areas	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 10 number provided by facility. During an interview with the Administrator on 02/14/19 at 04:42 P.M., the Administrator stated the in-house investigation and the police investigation were completed and found the medications were missing but there were no charges filed due to lack of evidence. The Administrator also stated her expectations were to assure medications for residents are not ever diverted or misappropriated.	F 602	of concern will be immediately addressed by the QA nurse to include education of staff, notification of DON and pharmacy of all discrepancies. The Director of Nursing and/or Administrator will review and initial audit weekly x 8 weeks then monthly x1 month for completion and to ensure all areas of concern were addressed. The DON will audit 100% of the Controlled Substance Return Form compared to pharmacy records weekly x 8 weeks then monthlyx1 month to ensure all narcotics medications returned to pharmacy were received. All areas of concern will be immediately addressed by the DON to include notification of pharmacy for all discrepancies. The Administrator will review and initial the controlled substance return form weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will compile the results of the controlled substance audit tool, manifest audit and controlled substance return audit and present to the QA Executive Committee meeting Monthly x3 month. The Executive QA Committee will meet and review the Controlled Substance Audit Tool, Manifest Audit and Controlled Substance Return Audit monthly x 3 months to identify and potential trends and determine the need for action and/or frequency of continued monitoring.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/15/19

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	345491	A. BUILDING _____ B. WING _____	C 02/15/2019

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F 689	Continued From page 11 §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 record reviews, observations, resident and staff interviews, the facility failed to ensure a resident's environment is free from accident hazards by not securing smoking materials for 1 of 1 sampled resident. (Resident # 11) The findings included: Resident # 11 was admitted to the facility on 5/31/2018 with diagnoses which included depression, dementia, anxiety, muscle weakness and hyperlipidemia. Resident #11's quarterly Minimum Data Set (MDS) dated 1/29/2018 coded the resident as moderately impaired with his cognition, independent with her bed mobility, transfer, dressing eating and toileting. Resident # 11's care plan dated 2/1/2019 identified the following focus area: "Resident is an independent and safe smoker or user of tobacco products." The goal was for resident will continue to smoke safely in designated areas thru next review. The interventions included: Assist resident in obtaining smoking materials from secured storage area upon request, upon return	F 689	On 2/14/2019, the Administrator removed all smoking paraphernalia from Resident #11 room and secured at the Nurses Station. On 2/14/2019, Resident #11 was educated by Administrator on Smoking to include (1)smoking policy,(2)storage of Smoking materials, (3)designated outside smoking area, (4) Determination of Resident's supervision needs, (5)Policy Violations. Resident #11 verbalized understanding. On 2/22/2019, the treatment nurse updated the smoking assessment for Resident #11. Resident was deemed safe smoker and care plan was updated. On 2/20/2019 100% audit of all resident rooms to include Resident #11 was completed by the Nurse Supervisor, Administrator, assigned hall Nurses, Quality Assurance (QA) Nurse, Social Worker, Activities Director, and/or Treatment Nurse to ensure no Resident had smoking paraphernalia in the rooms. All areas of concern were immediately	

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F 689	Continued From page 12 of smoking materials by resident, ensure materials are placed in secured storage area. Facility smoking policy dated 2/1/2018 documented " in this facility, smoking materials include but are not limited to any tobacco products, tobacco substitute products, pipes, electronic cigarettes, other electronic smoking devices, matches, lighters, other sources of ignition , and related products. All resident smoking materials are maintained in 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 smoking materials at any time to other residents. Observation of Resident #11 smoking cigarettes was completed on 2/13/2019 at 2:00 PM. Resident # 11 was observed smoking cigarettes in designated smoking area. Resident was observed with a cigarette lighter. During an interview with Resident # 11 she reported she kept her own cigarettes and the lighter. During an observation of the Resident # 11's room on 2/14/2019 at 9:30 AM, the resident pointed out her jacket behind the door and her purse which was in her closet as places that she kept her smoking materials. Interview with the Unit Manager (UM) was conducted on 2/14/2019 at 10:00 AM. UM reported Resident # 11 kept her own smoking materials because she was an independent smoker. The UM was reminded about the facility's policy. UM responded she was not aware that independent smokers were not to keep their	F 689	addressed by the Director of Nursing (DON), QA Nurse, Treatment Nurse, Assigned hall nurse, Social Worker, Administrator, and/or Activity Director to include removing and securing smoke materials and education of resident and/or resident representative on storage of smoking paraphernalia / smoke policy. Care plans were updated for any resident not following smoking policy by the Minimum Data Set Nurse (MDS). Audit completed by 2/22/2019. On 3/4/2019, 100% audit of Resident progress notes x 30 days to include Resident #11 was initiated by the Nurse Supervisor and Administrator to identify any other Residents who had smoking paraphernalia in the facility. There was 1 concern of which Administrator and Hall Nurse had already addressed by removal and securing of smoke paraphernalia, re-educate Resident on smoking policy, contacting RR, initiating 30 day discharge. On 3/5/2019, 100% audit of all admissions x30 days was initiated by the social worker / admission director to ensure the smoking policy to include storage of smoking paraphernalia was reviewed and a copy given to any resident to include Resident #11 and/or Resident Representative who smokes or desires to smoke. All identified areas of concern will be immediately addressed by the Social Worker/Admission Director during the audit to include review of smoking policy and notification of nursing staff of any resident who desires to smoke for further	

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F 689	Continued From page 13 smoking materials in their rooms. Interview with the Administrator was conducted on 2/14/2019 at 11:30 AM. Administrator reported that her expectations were for all the smoking materials to be maintained in a secure area. Administrator added she was not aware Resident # 11 was keeping her own smoking materials. She added Resident 11's smoking materials will be kept in a secure area immediately.	F 689	assessment. On 2/18/2019, 100% audit of all Resident care plans was initiated by the Minimum Data Set Nurse (MDS) to ensure all Residents' who smoke or desire to smoke were care planned for smoking to include whether Residents were identified as "independent" or "supervised" smokers. All care plans/care guides were updated to reflect the current smoking status during the audit. On 2/18/2019, 100% audit of smoking assessment for all residents who smoke to include Resident #11 was initiated by the Nursing Supervisor to ensure all residents who smoke or desire to smoke have had a smoking assessment to determine if resident is safe to smoke independently or is unsafe and requires supervision. All areas of concern was immediately addressed by the Nursing Supervisor to include completion of smoke assessment, updating care plan/care guide as indicated. On 2/18/2019, 100% interview was conducted by the Social Worker and Activities Director of all alert and oriented resident to identify any resident that smokes or has desire to smoke to include (1) Do you smoke or have a desire to smoke? (2) If yes do you wish to stop smoking? (3) If you wish to stop smoking, do you wish to have an intervention to stop smoking? (4) Have you been educated on the facility smoking policy? (5) Do you understand that smoking with	

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F 689	Continued From page 14	F 689	Oxygen is dangerous and could cause an explosion? (6) Do you know where the designated smoking area is located? (7) Do you understand that smoking is not allowed outside of these areas? (8) Do you understand that all smoking paraphernalia must be secured at the nurses station and that smoking paraphernalia may not be stored in your room? There were 4 identified Residents that smoke or verbalized desire to smoke. There were no identified concerns during the interviews. On 2/15/2019, A Resident council Meeting was held to review smoking at the facility to include (1) Smoking policy, (2) Storage of smoking material, (3) Designated outside Smoking Areas, (4) Determination of Resident's supervision needs, (5) Policy violations. Ten Residents attended the meeting. All alert and oriented Residents not present will be in-serviced 1:1 by the Activities in regards to smoking policy. On 2/22/2019, The Business Office Manager mailed a copy of the Facility Smoking Policy to the Resident Representative of the four identified smokers in the facility. On 3/6/2019, the Business Office Manager mailed a copy of the Facility Smoking Policy to the Resident Representative of all Residents. On 2/22/2019, a bright colored sign was posted at the facility entrance and the entrance of the designated smoking area stating "for the safety of our Residents	

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F 689	Continued From page 15	F 689		

please so not provide any resident with smoking material without checking with Nursing staff".

On 2/15/2019, 100% in service was imitated by the DON, for all facility staff to include agency in regards to "Procedures for safe smoking" to include; (1) smoking is only allowed in the designated smoking area, (2) Location of smoking are, (3) storage of smoking paraphernalia, (3) Storage of smoking paraphernalia, (4) Location of smoke aprons, fire extinguishers, smoke blankets, and smoking containers, (5) smoking around oxygen is not allowed, (6) Procedure of residents on oxygen who smoke, (7) Designated smoke times for supervised smoker, (8) Resident are not allowed to provide other resident smoking paraphernalia to include lighters, matches and / or cigarettes. In-service completed by 3/5/2019. All newly hired facility and agency staff will be in-serviced during orientation by the Staff Facilitator in regards to Procedures for Safe Smoking.

On 2/18/2019, and in-service was completed by the Administrator with the Admission Coordinator in regards to Reviewing Smoking policy on admission to include, (1) the admission coordinator must review the facility smoking policy with all admissions or re-entry to the facility, (2) the resident and resident representative should be provided a copy of the smoking policy with a signed copy placed in resident medical record; (3) any resident who smokes or desires to smoke

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F 689	Continued From page 16	F 689	must be immediately referred to the nursing staff for further evaluation; (4) all smoking paraphernalia must be removed and placed at the nursing station / cart for secure storage. All newly hired Admission Coordinators will be in-serviced during orientation by the Administrator in regards to Reviewing Smoking Policy on Admission. 25% audit of resident rooms will be completed by the assigned hall nurses and RN Supervisor to ensure smoking paraphernalia is not stored in resident rooms to include resident #1 utilizing the Smoking Paraphernalia Audit Tool weekly x 4 weeks, then monthly x 1 month. All identified areas of concern will be immediately addressed by the Nurse Supervisor and assigned Hall Nurses to include removal and securing smoking paraphernalia, re-education of staff and/or Resident, completion of smoking assessment and updating care plan/care guide as indicated. The Director of Nursing will review and initial the smoking paraphernalia audit tool weekly x 4 weeks then monthly x 1 month to assure all areas of concern were addressed. 10% alert and oriented Resident questionnaires in regards to smoking or desire to smoke will be completed by the Social Worker/Admission Director and/or Activities Director with all alert and oriented Residents to include resident #11 utilizing the Smoking Questionnaire weekly x4 weeks, then monthly x 1 month to identify and Resident who smokes or	

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F 689	Continued From page 17	F 689	desires to smoke and Resident knowledge on the smoking policy. All concerns identified will be immediately addressed by the Social Worker/Admission Director and the Nurse Supervisor during the audit to include re-educating resident, completing smoking assessment and removing/securing smoking paraphernalia. The Director of Nursing will review and initial the Smoking Questionnaire weekly x4 weeks then monthly x 1 month to assure all areas of concern were addressed. 10% audit of all admission will be completed by the Medical Records Director utilizing the smoking policy admission audit tool weekly x 4 weeks, monthly x 1 month to ensure the smoking policy is reviewed with all residents include resident #11 and resident representative at time of admission and that any resident who smokes or desires to smoke is referred to the nursing staff for further assessment. The administrator will review and initial the smoking policy admission audit tool weekly x4 weeks then monthly x1 month to ensure all areas of concern were addressed timely. The Administrator will forward the results of the smoking paraphernalia audit tool, smoking policy admission audit tool and the smoking questionnaire to the Executive QA Committee monthly x2 months. The Executive QA committee will meet monthly x2 months and review the smoking paraphernalia audit tool,	

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F 689	Continued From page 18	F 689	smoking policy admission audit tool and the smoking questionnaire to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 756 SS=D	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 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.	F 756		3/15/19

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F 756	Continued From page 19 §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 record reviews, observations and staff interviews, the facility failed to document a rationale for Klonopin medication use for 1 of 5 sampled residents with behavioral symptoms. (Resident # 11) The findings included: Resident # 11 was admitted to the facility on 5/31/2018 with diagnoses which included depression, dementia, anxiety, muscle weakness and hyperlipidemia. Resident #11's quarterly Minimum Data Set (MDS) dated 1/29/2018 coded the resident as moderately impaired with his cognition, independent with her bed mobility, transfer, dressing eating and toileting. Resident # 11's care plan dated 2/1/2019 identified the following focus area: "Resident use of psychotropic drugs with the potential for or characterized by side effects due to diagnosis of: anxiety, depression and insomnia (Zoloft, Clonazepam and Restoril are prescribed). " The goal was for resident will show minimal/ no side effects of medications taken through next review. The interventions included: Evaluate	F 756	On 3/5/2019, the Quality Assurance nurse obtained the rational and risk/benefits statement requested from the Pharmacy recommendations for resident #11 from Resident #11's physician. On 3/5/2019, 100% audit of all pharmacy recommendations, to include resident #11, x90 days was reviewed by the nurse supervisor and the administrator, to ensure all pharmacy recommendations were completed by the physician to include rationale and risk/benefit statement for declining pharmacy recommendations when indicated. All areas of concern will be immediately addressed by the Nursing Supervisor to include following up with the physician in regards to completing recommendation with rationales and risk/benefits statement, obtaining new orders as indicated, notification of pharmacy of any follow up or updates and notification of RR for any change in plan of care. The audit was completed on 3/7/2019 On 3/6/2019, 100% in-service was initiated by the Administrator and Nursing Supervisor with the Medical director and	

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F 756	Continued From page 20 effectiveness and side effects of medications for possible reduction/ elimination of psychotropic drugs in consultation with pharmacy consultation. Consultation Pharmacist's Medication Regiment Review dated 2/1/2019 documented "Repeat recommendation from January 2019. Please add Medical Doctor's response. Please add the clinical rationale to the medical record. Resident is currently on the following: Zoloft 75 milligram every day, Klonopin 0.5 take by mouth every morning and Restoril 7.5 milligram every night for insomnia. Resident has tolerate a dose reduction of klonopin since October 2018. There have no reports of mood or behavior problems. Please consider discontinuation of Klonopin at this time and continue Zoloft and Remeron as ordered (benefits outweigh risks) if no changes, please provide rationale and benefit/ risk statement below." No response was documented from the physician. Interview with the pharmacist was conducted on 2/13/2019 at 3:00 PM. The Pharmacist reported she recommended the drug rationale for Klonopin for the last 3 months and she was still waiting for the response from the doctor. She reported her expectation was for the physician to respond to her recommendations by her next drug review. Interview with the Physician was conducted on 2/13/2019 at 4:00 PM. Physician reported that he had not responded to the pharmacist recommendations because of too many paperwork that he was responsible for and trying to catch up with signing the paperwork was a challenge.	F 756	all facility physicians in regards Pharmacy Recommendations to include (1) reviewing and completion of pharmacy recommendations monthly and (2) completing rationales and risk/benefits statement for declining pharmacy recommendation when indicated. In-service will be completed by 3/15/2019. All newly hired physicians or Medical Directors will be in-serviced by the Administrator during orientation in regards to Pharmacy recommendations. The Medical Director and all physicians will be educated by the Administrator, DON, and/or Nursing Supervisor in regards to completion of pharmacy recommendations to include completing rationales when indicated and will be completed by 3/15/2019. 100% audit of Pharmacy Recommendations will be completed by RN Supervisor monthly x3 months utilizing the Pharmacy Recommendations Audit Tool to ensure all recommendations have been reviewed/completed by the physician with rationales and/or risk/benefits statements for declining pharmacy recommendations when indicated, new orders updated and RR notified of any changes in plan of care to include new medication orders/labs. All areas of concern will be immediately addressed by the Nurse Supervisor to include notifying the physician for completion of all pharmacy recommendations, updating orders, notification of RR and re-education of the Medical Director/Physician when indicated. The	

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F 756	Continued From page 21 Observation of Resident #11 was completed on 2/13/2019 at 2:00 PM. Resident # 11 was observed smoking cigarettes in designated smoking area. Resident was observed with a cigarette lighter. During an interview with Resident # 11 she reported she was doing fine at the moment and was just missing going back at her home. Interview with the Director of Nursing (DON) was conducted on 2/14/2019 at 10:00 AM. DON reported her expectation was to get response from the physician for a rationale after receiving the pharmacy recommendations for drug reduction. DON reported at the moment they will try to follow up with the physician to document the rationale for continuing of the psychotropic drug use for Resident # 11. Interview with the Administrator was conducted on 2/14/2019 at 11:30 AM. Administrator reported that her expectations was for the physician to document a rationale for psychotropic drug use after receiving the pharmacy recommendations. The Administrator stated she was going to follow up with the physician to make sure he documents rationale for psychotropic drug use.	F 756	DON will review the Pharmacy Recommendations Audit Tool monthly x3 months to ensure all areas of concern have been addressed. The DON will forward the Pharmacy Recommendation Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Pharmacy Recommendation Audit Tool monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		3/15/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to serve residents meals in dinnerware that were free of stains and discoloration for 54 of 54 insulated tray tops and bottoms. The findings included: During the initial tour of the kitchen on 02/11/19 at 10:28 AM, observations were made of 54 insulated tops and bottoms that are used to deliver residents meals in. The inside of the insulated tops and bottoms were stained with black matter, dingy, cracked, discolored and worn. During an observation on 02/11/19 at 12:15 PM, residents in the main dining room lunch meals were delivered in the insulated tops and bottoms that were stained with black matter, dingy, cracked, discolored and worn. The facility staff were observed removing the residents plated food from the insulated containers directly in front of each resident. During an observation on 02/11/19 at 12:30 PM,	F 812	On 2/18/2019, Administrator requested and obtained approval for replacement of current dietary tray system with a new dietary tray system from Corporate Management. On 2/22/2019 and 2/28/2019 Dietary Manager emailed sales representative for date of delivery. On 3/1/2019, the Administrator found out a signature was needed by company. Administrator resent approval information along with a singed quote for new dietary tray system to the US Foods Representative. On 3/5/2019, the Administrator contacted the US Foods Representative to verify confirmation of the order processing and to obtain tracking information On 3/6/2019, the Administrator was notified by US Foods Representative, that the initial signed quote needed to be revised and resubmitted. The	

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	345491	A. BUILDING _____ B. WING _____	C 02/15/2019

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F 812	Continued From page 23 residents in their room lunch meals were delivered in the insulated tops and bottoms that were stained with black matter, dingy, cracked, discolored and worn. The facility staff were observed removing the insulated lid and the resident ate plated lunch on the insulated bottom. During an observation on 02/13/19 at 7:20 AM, Cook #1 was plating food for 54 residents and placing the plated food in the insulated bottoms and placing the insulated top on the plated food that were stained with black matter, dingy, cracked, discolored and worn. During an interview with Cook #1 on 02/13/19 at 7:30 AM, he stated that he felt that the resident's meals should not be served on the filthy insulated tray bottoms and tops. During an interview with the Certified Dietary Manager (CDM) on 02/13/19 at 7:35 AM, he stated that the facility has soaked the trays in bleach trying to remove the stains. He further stated that the nursing assistants remove the food from the trays in the dining room. He stated it is his expectation that the residents meals be served on clean and stain free insulated containers. During an interview on with the Regional Vice President 02/14/19 at 9:15 AM, he stated he has approved the order for the new tray system on 02/14/19 and they will arrive at the facility in 14 days. During an interview with the Administrator 02/14/19 at 9:20 AM, she stated that the facility received a quote last year for the new tray system in the kitchen and it was never approved and	F 812	Administrator obtained a revised quote / signed new quote and forwarded to the US foods Representative for processing with request to rush order. On 3/7/2019 100% in-service was initiated with the Dietary Manager and Dietary Staff by the Administrator in regards to Dinnerware/Meal Trays to include (1) dinnerware and meal trays are to be free of stains, cracks, and discoloration and (2) if Dinnerware is observed to have cracks, stains, or discoloration, the Dietary Manager will report finding to the Administrator for replacement of dinnerware/meal trays as appropriate. In-service will be completed by 3/15/2019. All newly hired dietary staff will be in-serviced during orientation by the Staff Facilitator and/or Dietary Manager in regards to Dinnerware/Meal Trays. The Administrator will contact US Foods weekly via email for tracking of the New Dietary Tray System until New Dietary Tray system received in the facility. The projected date of delivery is 3/15/2019 The dietary Manager will inspect all dinnerware/meal trays weekly x8 weeks then monthly x1 month utilizing the dinnerware/Meal Tray Audit Tool to ensure all dinnerware/meal trays are free of stains, cracks and discoloration. Any area of concern will be immediately addressed by the Dietary Manager during the audit to include removal of any stained, cracked or	

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F 812	Continued From page 24 there was no follow-up. The Administrator further stated it was her expectation that the residents' meals be served on a clean and presentable tray.	F 812	discolored dinnerware/meal trays and notification of the Administrator for replacement. The Administrator will review and initial the Dinnerware/Meal Tray Audit Took weekly x8 weeks then monthly z 1 month to ensure all areas of concern were addressed. The Administrator will forward the Dinnerware/Meal Audit Tool to the Executive QA Committee x3 months. The Executive QA Committee will meet monthly x3 months and review the Dinnerware/Meal Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	