

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/17/2019
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NAME OF PROVIDER OR SUPPLIER MOORESVILLE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115
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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/14/19 through 10/17/19. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID 150Y11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 10/14/19 through 10/17/19. There was a total of 7 allegations investigated and 3 were substantiated with a citation and 2 were substantiated without a citation. Event ID# 150Y11.	F 000		
F 565 SS=E	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.	F 565		11/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/08/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 565	<p>Continued From page 1</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to resolve grievances that were reported in the resident council meeting for 11 of 11 consecutive months.</p> <p>The findings included:</p> <p>An observation of the resident council meeting was made on 10/16/19 at 2:30 PM and revealed an issue with the resolution of grievances in regard to call bell response time. The council as a group indicated that they continued to have to wait 1 to 2 hours for staff to respond to their call bell. The council further stated that the staff continued to turn off the call light and say they would be back and never come back.</p> <p>The residents in the council meeting reported that not all grievances were resolved, and they were not given a reason as to why. The Resident Council president stated that each month during the meeting they reviewed the minutes from the previous month and the council would talk about</p>	F 565	<ol style="list-style-type: none"> 1. Resident council meeting minutes were reviewed from December 2018 through September 2019 and found that each month there were concerns presented by the council that call lights were not answered in a timely manner. Moving forward, the Activity Director and/or Activity Assistant will write individual grievances regarding call lights so the issue can be addressed individually and timely. 2. All residents are at risk of timely resolutions of grievances. Center Executive Director will conduct a resident council meeting on 11/12/19 to address the ongoing concern with call bells and introduce plan to address this concern. 3. The Center Executive Director will re-educate the Activities Director and Activities Aide to write individual grievances on call light issues. The Center Executive Director will meet with the Resident Council President to discuss 	

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F 565	<p>Continued From page 2</p> <p>if the issues were still a concern. If the issues were still a concern the Activity Assistant (AA) documented the concern again and any new concerns and then passed those concerns along to the appropriate staff member for resolution.</p> <p>Review of the resident council meeting minutes from December 2018 to September 2019 were reviewed.</p> <p>a. Review of the December 28, 2018 resident council meeting minutes revealed the council reported that it took too long for staff to answer call lights and to provide care.</p> <p>Review of the response provided to the council dated 01/05/19 stated that the Director of Nursing (DON) at the time spoke to the nursing assistants about being more attentive. The response was signed by the DON.</p> <p>b. Review of the January 28, 2019 resident council meeting minutes revealed the council reported that it took the nursing assistants too long to answer call bells.</p> <p>Review of the response provide to the council dated 02/04/19 stated the Director of Nursing at the time addressed call bell response in the staff meeting and was told it had been getting better. The response was signed by the Director of Nursing at the time.</p> <p>c. Review of the February 26, 2019 resident council meeting minutes revealed the council reported that call lights were staying on for a very long time. The council also reported that nursing assistants would come in and turn off their call light and say they would be back and never come</p>	F 565	<p>writing individual grievances on call light response times. Center Executive Director and/or designee will re-educate staff on the grievance policy.</p> <p>4. The Center Executive Director and/or designee will conduct random call bell audits on all three shifts 3x's per week for four weeks, then 2x's per week for two weeks, and then once per week for two weeks to determine the length of time it takes to answer call lights. Call light grievances will be audited weekly to determine improved response time. Center Executive Director will review Resident Council Minutes monthly as part of the Quality Assurance and Performance Improvement Committee meeting to ensure that concerns have been addressed month to month with documented resolution. Results of the audit to be brought to Quality Assurance and Performance Improvement Committee for further review and recommendations.</p>		

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F 565	<p>Continued From page 3 back.</p> <p>Review of the response provide to the council dated 03/15/19 revealed the Director of Nursing at the time held a staff meeting on 03/10/19 and again during the week of 03/24/19 to address the concerns. The response was signed by the Director of Nursing at the time.</p> <p>d. Review of the March 29, 2019 resident council meeting minutes revealed that the council reported that it still took 1 to 1.5 hours for call bells to be answered.</p> <p>Review of the response provided to the council with no date provided read, the resident was spoken to and asked to please report sooner so the staff could be addressed. There was no staff signature on the response provided to the council.</p> <p>e. Review of the April 24, 2019 resident council meeting minutes revealed the council reported the staff were slow to answer call bells.</p> <p>Review of the response provided to the council with no date provided indicated the staff member had spoken to staff and they will try to be quicker with their response time. There was no staff signature on the response provide to the council.</p> <p>f. Review of the May 28, 2019 resident council meeting minutes revealed the council reported it took the nursing assistants a long time to answer call bells.</p> <p>Review of the response provided to the council dated 06/10/19 read, this has been addressed several times and will be re-addressed to answer</p>	F 565			

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F 565	<p>Continued From page 4</p> <p>call lights timely. The response was signed by the Assistant Director of Nursing.</p> <p>g. Review of the June 24, 2019 resident council meeting minutes revealed the council reported their call lights were not answered in at timely manner.</p> <p>Review of the response provided to the council with no date provided by the current Director of Nursing read in part, there will be a new procedure implemented called "NO PASS ZONE." First, call lights are not to be turned off until the need is met. "NO PASS ZONE" means no staff member is to pass a call light that is on without going into see if they can be of assistance. If the staff member cannot meet the need, this will be reported to the nurse and the light will remain on until the need is met. The response was signed by the current Director of Nursing.</p> <p>h. Review of the July 30, 2019 resident council meeting minutes revealed the council reported they have to wait "forever" for call bells to be answered and then the staff turned the light off and don't help them.</p> <p>Review of the response provided to the council dated 08/26/19 indicated no specific response. There was an attachment that read, NO STAFF MEMBER should pass by a call light that is on. All call lights are to be promptly answered. All call lights are considered no pass zones. If you answer a call light and cannot meet the need, leave the call light on and find a staff member to assist the resident. The response was signed by the current Director of Nursing.</p> <p>i. Review of the August 27, 2019 resident council</p>	F 565		

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F 565	<p>Continued From page 5</p> <p>meeting minutes indicated the council reported that a resident had waited over an hour for her call bell to be answered.</p> <p>Review of the response provided to the council dated 09/03/19 indicated no direct response to the wait time but indicated the issues reported during the meeting would be discussed at the staff meeting on 09/26/19. The response was signed by the current Director of Nursing.</p> <p>j. Review of the September 25, 2019 resident council meeting minutes indicated the council reported that it was still taking 0.5 to 1 hour for call lights to be answered and this was an ongoing issue.</p> <p>Review of the response provided to the council dated 09/30/19 indicated the current Director of Nursing (DON) plan to have the weekend supervisor do an audit on call lights on weekends as well as during the week. The response was signed by the DON.</p> <p>An interview was conducted with the Administrator on 10/17/19 at 11:37 AM. The Administrator stated that the AA recorded the meetings of the resident council. After the meeting the concerns reported during the resident council meeting would be given to the appropriate department and then discussed in the morning meeting. The Administrator added that they had initiated a rounding schedule to check for call lights but as the facility prepared for their annual inspection their focus got switched. She added that she expected each department head to address the grievance voiced either in resident council or from an individual and document the steps that were taken to resolve the grievance. If</p>	F 565		
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F 565	<p>Continued From page 6</p> <p>the same concern or grievance kept coming up, then she indicated they needed to go back and look at what had been done and try something different to achieve resolution to the council or resident.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/17/19 at 12:57 PM. The DON stated that she had received the concerns from the resident council, and she implemented the NO PASS ZONE to help improve call bell response time. The DON stated that from her observations the call bell response time was much better, and thought some members of the resident council may be dwelling on the issue. The DON stated that the facility has had a lot of turnover in administration and lots of agency staff which contributed to the concerns brought up by the council. The DON stated that she had been working on hiring new staff and setting the expectation of call bell response time. The DON stated that she expected each concern of the resident council to be clearly documented and then the steps listed to provide resolution. The DON stated if the same issue kept coming up then they needed to identify another way and try to bring resolution to our residents.</p> <p>An interview was conducted with the AA on 10/17/19 at 4:29 PM. The AA indicated that either she or the Activity Director would sit in on the monthly resident council meeting to take notes. The AA stated that every month there were complaints about call bells not being answered. She added that whatever they were putting in place was not helping things get better.</p>	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		11/14/19

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F 584	<p>Continued From page 7</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p>	F 584		

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F 584	<p>Continued From page 8</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair a metal hinge that was loose with metal screws that were sticking outward on a fire door for 1 of 6 sets of double fire doors (200 hall fire door).</p> <p>Findings included:</p> <p>An observation on 10/14/19 at 12:27 PM of the double fire doors on the 200-hall revealed both doors were in the open position. The door on the right side facing toward the corner of the 200 halls had a metal hinge near the bottom of the door that was loose and was sticking outward. The observations further revealed one of the screws was missing and the remaining screws were loose and the heads of metal screws were sticking outward with sharp edges.</p> <p>An observation on 10/15/19 at 10:32 AM of the double fire doors on the 200-hall revealed both doors were in the open position. The door on the right side facing toward the corner of the 200 halls had a metal hinge near the bottom of the door that was loose and was sticking outward. The observations further revealed one of the screws was missing and the remaining screws were loose and the heads of metal screws were sticking outward with sharp edges.</p> <p>An observation on 10/16/19 03:33 PM of the double fire doors on the 200-hall revealed both doors were in the open position. The door on the right side facing toward the corner of the 200 halls had a metal hinge near the bottom of the</p>	F 584	<ol style="list-style-type: none"> 1. Metal hinge with loose screws on one of the six fire doors has been fixed. All other hinges on the remaining fire door have been observed to have no loose screws. 2. All fire doors have the ability to have loose screws on the hinges. 3. The Maintenance Director and Maintenance Assistant will be re-educated on keeping hinges on the six sets of double fire doors in good repair which includes checking the screws on the hinges. Center Executive Director and/or designee will re-educate staff on observing for repairs and filling out work orders for the needed repairs. 4. Random 5x's per week screws on the six fire doors will be checked to ensure the screws are in secure and the hinges are not loose. This task was added to the TELS system on 11/08/19 to be checked on a weekly basis. Results of audits to be brought to Quality Assurance Performance Improvement Committee for further review and recommendations. 	

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F 584	Continued From page 9 door that was loose and was sticking outward. The observations further revealed one of the screws was missing and the remaining screws were loose and the heads of metal screws were sticking outward with sharp edges. An interview and environmental tour on 10/17/19 at 2:54 PM with the Maintenance Director revealed he had only worked at the facility since July 2019 and he had an Assistant who had started last week. He confirmed the facility utilized an electronic work order system. He stated staff were encouraged to report any repairs they saw in the electronic work order system and he and his assistant checked the work orders on a routine basis and they made repairs as soon as they could. He confirmed the hinge on the 200-hall fire door had one screw missing and the lower hinge was coming off the door. He stated he had not received any work orders to repair the loose hinge on the fire door on the 200 hall and it was a safety hazard and it should have been reported and repaired. He further stated there had been no injuries reported to him regarding the loose hinge on the fire door. An interview and environmental tour on 10/17/19 at 3:07 PM with the Administrator revealed the Maintenance Department reported to her. She stated it was her expectation for maintenance staff to walk the building and check for repairs that needed to be made. She explained if other staff see something like the loose hinge on the fire door on the 200 hall, she expected for them to report it immediately and it should be fixed immediately.	F 584			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		11/14/19	

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F 585	<p>Continued From page 10</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for</p>	F 585		

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F 585	Continued From page 11 completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 585		

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F 585	<p>Continued From page 12</p> <p>taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident and staff interview the facility failed to provide a written grievance summary with resolution to the resident who filed the grievance for 1 of 2 residents reviewed for grievances (Resident #69).</p> <p>The findings included:</p> <p>Resident #69 was admitted to the facility on 12/27/18 with diagnoses that included: cerebral vascular accident, hemiplegia, and weakness.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated 07/05/19 revealed that Resident #69 was moderately cognitively impaired and required extensive assistance with activities of daily living.</p> <p>Review of a grievance filed on 07/10/19 by Resident #69 and recorded by the Activity Assistant (AA) read in part, the grievance was filed and assigned to a former Unit Manager (UM). Under a section titled Factual terms: there was nothing that explained what the grievances</p>	F 585	<ol style="list-style-type: none"> 1. Center Executive Director followed up with Resident #69 on 11/6/19 regarding the grievance she filed on 7/10/19. Resident believes call bell issues have improved since she filed the grievance in July. Resident was given a copy of the completed grievance on 11/6/19. 2. All residents have the potential to be affected by the practice. Alert and oriented residents were interviewed by the Social Services Department to ensure that they felt their concerns are addressed timely. A letter was sent to the family members regarding the Grievance Policy and follow up. 3. All Department Managers will be re-educated by the Center Executive Director on filling out the grievance form to completion and ensuring the Center Executive Director reviews and submits a copy of the grievance to the proper parties. All staff members who are able to take grievances will be educated on the 		

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F 585	<p>Continued From page 13</p> <p>was about. The AA signed the grievance. There was no written response to the grievance and no steps taken to provide resolution to Resident #69.</p> <p>Review of a quarterly MDS dated 09/11/19 revealed that Resident #69 was cognitively intact and required extensive assistance with activities of daily living.</p> <p>An interview was conducted with Resident #69 on 10/17/19 at 2:58 PM. Resident #69 recalled filing the grievance on 07/10/19 and stated her concern was the amount of time it took for staff to answer her call light. She further added she also had concerns about the staff coming in and turning off the call light and saying that they would come back but sometimes they would not come back. Resident #69 stated that if the staff did not come back, she would holler out and shake the bed rails to get their attention. She added that she generally only rang her call bell when she was ready to get up for the day and a lot of times they would leave and be gone for 30 minutes to an hour. She added that she used the clock on the wall directly in front of her bed to keep up with the time. Resident #69 confirmed that the staff were still coming and turning the light off without assisting with the care needed. She further stated that she did not recall getting a copy of the grievance or any written response about the steps the facility took to resolve the grievance. Resident #69 stated that the former UM talked to the staff that day about not turning off the call light until they had provided the care but endorsed that the issues were still occurring regularly.</p> <p>An interview was conducted with the former UM on 10/17/19 at 3:31 PM. The UM stated that she recalled the grievance that Resident #69 had filed</p>	F 585	<p>grievance procedure.</p> <p>4. From this point forward, grievances will be reviewed by the Center Executive Director to ensure the grievance has been completed accurately and to ensure the grievance has been resolved. Additionally, the Center Executive Director will ensure a copy of the grievance is given to the resident or responsible party who has filed the grievance. Random audits 5x's per week of grievances will be reviewed by the Center Executive Director to ensure correct completion of the grievance form and ensure a proper resolution has been determined and a copy is given to the resident and/or responsible party. Results of the audits to be brought to Quality Assurance and Performance Improvement Committee for further review and recommendations.</p>	

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F 585	<p>Continued From page 14</p> <p>on 07/10/19 and confirmed that she had been responsible for taking care of the grievance. She stated that she went and talked to Resident #69 about her concern and gathered more information and most of her concerns occurred on 2nd and 3rd shift. The former UM stated that she educated the staff on all 3 shifts and stayed over to 2nd shift to observe the staff answering call lights. She added that she left the education in-service with the supervisor to educate the 3rd shift when they arrived for work. The UM confirmed that Resident #69 was alert and oriented and able to voice her concerns to the staff. She further confirmed that she did not give Resident #69 a copy of the grievance or any written response as to what she did to resolve the grievance. The UM also stated that she followed up with Resident #69 two days later and asked her if the call bell response time was better and she stated yes.</p> <p>An interview was conducted with the Administrator on 10/17/19 at 11:37 AM. The Administrator stated that the any staff member could record a grievance and they were turned into the Social Worker to be given to the appropriate department. She added that each morning in the clinical meeting they discussed grievances that were in process and what their status was. The Administrator added that they had initiated a rounding schedule to check for call lights but as the facility prepared for their annual inspection their focus got switched. She added that she expected the grievance to be clearly documented and each department head to address the grievance voiced either in resident council or from an individual and document the steps that were taken to resolve the grievance. The Administrator stated that the written response</p>	F 585			

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F 585	Continued From page 15 had not been occurring they had only doing face to face follow up with the person filing the grievance. An interview was conducted with the Director of Nursing (DON) on 10/17/19 at 12:57 PM. The DON stated that she had received several concerns from the resident council and individual residents about call bell response time, and she implemented the NO PASS ZONE to help improve call bell response time. The DON stated that from her observations the call bell response time was much better. The DON stated that the facility has had a lot of turnover in administration and lots of agency staff which contributed to the concerns being voiced. The DON stated that she had been working on hiring new staff and setting the expectation of call bell response time. The DON stated that she expected each concern of the resident council or from an individual resident to be clearly documented and then the steps listed to provide resolution. An interview was conducted with the AA on 10/17/19 at 4:29 PM. The AA indicated that she took the grievance filed by Resident #69 on 07/10/19. She stated she wrote it on the grievance form and gave it to the former UM to be handled. The AA could not recall exactly what the issue was and confirmed that when she read the grievance it did not convey what Resident #69's grievance actually was. She believed Resident #69's concern had to do with call bell response time and stated she should have documented what Resident #69 had said.	F 585			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		11/14/19	

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F 600	<p>Continued From page 16</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and resident, Physician and staff interviews the facility neglected to follow Physician's orders to place a Bilevel Positive Airway Pressure machine on at bedtime and a Nurse neglected to assess the resident when a Nurse Aide reported the resident's oxygen saturation percentages dropped and her anxiety increased for a resident with severe chronic respiratory failure for 1 of 3 residents reviewed for abuse and neglect (Resident #310).</p> <p>Findings included:</p> <p>A hospital Discharge summary dated 09/09/19 revealed Resident #310 had severe congestive obstructive pulmonary disease (COPD) and was hypoxic (short of breath) with any exertion.</p> <p>Resident #310 was admitted to the facility on 09/10/19 with diagnoses which included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia (low</p>	F 600	<ol style="list-style-type: none"> 1. Facility nurse failed to protect resident #310 from abuse and neglect. Resident #310 no longer resides in the facility. Facility nurse failed to follow physician orders and assess resident for need of BiPAP after being informed by the CNA at least three times. Facility nurse was immediately suspended and reported to the Board of Nursing. Facility nurse was terminated from this facility. The facility did substantiate neglect on 9/18/19. 2. All residents have the potential to be affected. 100% audit of all current residents who have orders for CPAP/BiPAP were reviewed by the Center Nurse Executive to ensure that they have been receiving per order. 3. Center Nurse Executive and/or designee will re-educate licensed staff, to include agency, on neglect as it relates to following physician orders and assessing resident needs. New licensed staff and 	

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F 600	Continued From page 17 oxygenation), pneumonitis (lung infection), heart disease with heart failure and type 2 diabetes. A Physician's order dated 09/10/19 indicated to apply Bilevel Positive Airway Pressure (BiPAP) for sleep apnea daily at bedtime and remove in the morning. The order also indicated oxygen 6 liters per minute per nasal cannula continuously. A Nursing Documentation Note dated 09/11/19 at 9:33 AM, documented by Nurse #2, revealed in part Resident #310's oxygen saturation percentage was 88 and she was wearing a nasal cannula for oxygen administration. Further review of Nursing documentation revealed there was no nursing documentation from 9/11/19 at 9:33 AM to 09/12/19 at 9:33 AM. A facility document titled Weights and Vitals Summary dated 09/11/19 at 10:07 PM indicated Resident #310's pulse oximetry percentage was 93. A review of a Treatment Administration Record dated 09/11/19 revealed a check mark by Nurse #4 for the application of the BiPAP machine at bedtime. A 24-hour Initial Report completed by the Administrator revealed an incident date of 09/11/19 at 10:45 PM for neglect and fax confirmation revealed the report was submitted to the state agency on 09/12/19 at 6:07 PM. The allegation details revealed on 09/11/19 at 10:45 PM Resident #310 requested her BiPAP machine and Nurse Aide (NA) #1 said Nurse #4 was busy so NA #1 tried to assist. The report indicated Resident #310 reported no one came in after that until 3:00 AM and Nurse #4 then attempted to	F 600	agency will be educated on this matter during orientation. 4. Center Nurse Executive and/or designee will conduct 5x's per week of patient orders for BiPAP and CPAP to ensure orders are followed properly. Results of the audits to be brought to Quality Assurance and Performance Improvement Committee for further review and recommendations.		

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F 600	<p>Continued From page 18</p> <p>place the BiPAP on but Resident #310 refused due to the fact it was so late in the morning. The report further indicated there was no harm to Resident #310.</p> <p>A Nursing Documentation Note dated 09/12/19 at 9:33 AM revealed Resident #310's oxygen saturation percentage was 91 and she received oxygen through a nasal cannula.</p> <p>A 5 Day Working Report with a fax confirmation of 09/18/19 at 2:13 PM revealed NA #1 reported she went into Residents #310's room on 9/11/19 around 10:30 PM and Resident #310 needed assistance with putting on her BiPAP. The report further revealed NA #1 went to the nurse's station to get Nurse #4 and Nurse #4 replied she was busy and would go to Resident #310's room when she could get there. The report indicated NA #1 went back to Resident #310's room and told the resident she could try to assist her in getting the BiPAP on correctly. The report further indicated NA #1 took off Resident #310's oxygen and tried to apply the BiPAP but in doing so, Resident #310's oxygen level dropped to 68. The report revealed NA #1 put oxygen back on Resident #310 and went back to the nurse's station to report Resident #310's oxygen was low and she needed care. The report further revealed Nurse #4 again stated she was busy and replied Resident #310 was aware she needed to have her oxygen on. The report indicated NA #1 went back into Resident #310's room and told her to take deep breaths and her oxygen level came up. The report further indicated Nurse #4 denied any NA came to her with concerns about Resident #310's oxygen level or needed assistance with the BiPAP. The report revealed Nurse #2 remembered she heard a NA at the nurse's</p>	F 600		

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F 600	<p>Continued From page 19</p> <p>station around 10:30 PM who told Nurse #4 that Resident #310's oxygen level had dropped and she needed Nurse #4 to go to Resident #310's room to assist her. The report indicated Nurse #2 remembered hearing Nurse #4 state that Resident #310 knew she needed to wear oxygen. The report further indicated Nurse #4 was made aware of Resident #310's need but did not go in and assess Resident #310. The report also indicated Nurse #4 stated the first time she went into Resident #310's room was at 5:00 AM. The report revealed Resident #310 did not suffer any harm but she was upset with Nurse #4 because she did not come to her room and neglect was substantiated.</p> <p>A discharge Minimum Data Set (MDS) dated 09/21/19 revealed Resident #310 was cognitively intact for daily decision making. A further review of the MDS revealed Resident #310 required extensive assistance with activities of daily living and oxygen was indicated.</p> <p>A physician's order dated 09/21/19 indicated for Resident #310 to discharge to home on 09/22/19.</p> <p>An interview on 10/16/19 at 01:49 PM with NA #1 revealed she remembered Resident #310 and she wore oxygen and used a BiPAP machine at night. She explained on 09/11/19 she was assigned to Resident #310 during the 3:00 PM to 11:00 PM shift. She stated Resident #310 had a personal pulse oximeter that she wore continuously to monitor her oxygen levels because she was very anxious about them. She explained Resident #310 rested most of that evening but at bedtime she was worried about who was going to put her BiPAP machine on. NA #1 stated she went to the Nurse's station and</p>	F 600			

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F 600	<p>Continued From page 20</p> <p>Nurse #4 was seated in front of a computer. She explained she told Nurse #4 that Resident needed assistance with her BiPAP machine but Nurse #4 stated she was busy with stuff she had to do, so NA #1 went back to Resident #310's room and told her she would assist her. She explained when she put the BiPAP on it went right over her head and she hooked the tubing to the oxygen concentrator and turned it on. She stated Resident #310 had her pulse oximeter on her finger and said her oxygen saturation percentage was dropping. She explained Resident #310 told her to take the BiPAP off and put her oxygen back on. She stated Resident #310's oxygen saturation percentage dropped to 68 but after she took 2 deep breaths her oxygen saturation percentage started coming back up. She further stated Resident #310's skin color did not change but she was very anxious. She explained she went back to the Nurse's station and Nurse #4 was sitting down typing on a computer and NA #1 told her what had happened and asked her to go check on Resident #310. She stated Nurse #4 said she was busy and would go when she could. She further stated this was the first time a Nurse had not responded to her request to check on a resident. She confirmed she reported off to NA #2 at 11:00 PM because NA #2 was assigned to Resident #310 during the night shift.</p> <p>Attempts to contact NA #2 were unsuccessful.</p> <p>A telephone interview on 10/17/19 at 11:12 AM with Nurse #4 confirmed she worked from 11:00 PM on 09/11/19 to 7:00 AM on 09/12/19 and was assigned to care for Resident #310. She stated she recalled Resident #310 was alert and did not recall there was a problem with her BiPAP. She stated she did not put the BiPAP machine on</p>	F 600		

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F 600	<p>Continued From page 21</p> <p>Resident #310 on 09/11/19 but she documented the BiPAP as part of her regular charting because she thought the resident could put it on by herself. She explained in the early morning on third shift on 09/12/19 when she went to Resident #310's room and the resident did not complain about the BiPAP to her. She further stated she did not recall a NA told her to go to Resident #310's room or to assist Resident #310 with her BiPAP on 09/11/19 during the 11:00 PM to 7:00 AM shift.</p> <p>An interview on 10/16/19 at 2:30 PM with Nurse #2 revealed she worked a double shift on 09/11/19 was assigned to provide care to Resident #310 from 7:00 AM until 11:00 PM on 09/11/19. She stated she remembered Resident #310 and recalled she was admitted to the facility for short term rehabilitation and she wore oxygen all the time. She explained Resident #310 was very anxious about her oxygen saturation percentages and even though she had her own pulse oximeter they used the facility machine to check her pulse oxygenation percentages and recorded them in her electronic medical record. She further explained it was the normal process for the Nurse to put the BiPAP machine on a resident at bedtime. She stated on 09/11/19 she was finishing her shift around 11:00 PM and Nurse #4 was assigned to Resident #310 for the night shift. She further stated NA #1 came to the Nurse's station and told Nurse #4 that Resident #310 wanted her to come to her room and put her BiPAP machine on. She explained Nurse #4 did not go to Resident #310's room and then NA #1 came back a second time and told Nurse #4 to go to Resident #310's room. She stated she did not hear NA #1 say anything about low oxygen saturation percentages or respiratory distress.</p>	F 600		

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F 600	<p>Continued From page 22</p> <p>An interview on 10/17/19 at 10:45 AM with a Physical Therapist revealed she remembered Resident #310 and recalled she was very anxious about her oxygen saturation percentages. She stated Resident #310 was pretty upset the morning of 09/12/19 when she went to visit her in her room. She explained Resident #310 wanted to file a grievance because she had requested several times the night before for the Nurse to assist her with her BiPAP machine. She stated the NA had tried to help her but she felt they didn't know how to do it. She further stated Resident #310 stated when they finally came in to put the BiPAP on, it was early morning and she told them she didn't want them to put it on since it was early morning. She explained Resident #310 stated she had lost sleep that night because she was anxious and upset because the Nurse did not help her with her BiPAP machine. She further explained she documented Resident #310's concerns and gave them to the Rehabilitation Director and he turned them in to the Administrator.</p> <p>A telephone interview on 10/17/19 at 12:57 PM with Resident #310 revealed she recalled the incident when the BiPAP was not put on by the nurse on 09/11/19. She explained she usually had the BiPAP put on by a nurse around 11:00 PM before shift change. She stated a NA came in her room, but she could not recall her name, and she told the NA she needed her BiPAP machine put on. She explained the NA tried to put the BiPAP on but couldn't get it on. She stated the NA left the room and around 11:00 PM and another staff person came in but couldn't recall their name, who said they were going to have a meeting and left her room and closed her door. She confirmed she didn't see any staff after</p>	F 600		

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F 600	<p>Continued From page 23</p> <p>that until 3:00 AM when a Nurse came in her room but couldn't recall her name and said they would put the BiPAP on. She stated she told them not to put it on because it was too close to morning to put it on. She also confirmed staff did not check her oxygen saturation percentages at 11:00 PM on 09/11/19 or during the night and she couldn't rest and was very anxious about her breathing.</p> <p>An interview on 10/17/19 at 4:26 PM with the Director of Nursing revealed she remembered an issue with Resident #310's BiPAP on 9/11/19. She explained she recalled NA #1 went to Nurse #4 and asked for assistance but Nurse #4 did not follow through. She stated they started an investigation when it was reported to them to find out what had happened. She explained she thought NA #1's attempts to assist Resident #310 with her BiPAP were sincere and she thought NA #1 was doing what she could as best as she could with the knowledge that she had. She stated it was her expectation Nurse #4 should have assisted Resident #310 with putting on her BiPAP machine. She further stated it was her understanding NA #1 tried on several attempts to get Nurse #4 to assist Resident #310 and she felt Nurse #4 had neglected Resident #310 when she did not assist her with her BiPAP or check on her when NA #1 requested for her to go to Resident #310's room.</p> <p>A telephone interview on 10/17/19 at 5:02 PM with Resident #310's Physician who was also the facility Medical Director revealed it was his expectation for Nurses to follow Physician's orders. He stated he did not see it as detrimental or harmful when Resident #310 did not have her BiPAP machine placed on her at bedtime given</p>	F 600			

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F 600	Continued From page 24 the fact she received continuous oxygen. He further stated if the Nurse did not put the BiPAP on Resident #310 this would be an example of not following the expectation to meet compliance with following Physician's orders. An interview on 10/17/19 at 5:23 PM with the Administrator revealed it was her expectation if a NA could not get a Nurse to go check a resident, they should go to a charge nurse or another nurse and ask for their assistance. She confirmed she started an investigation as soon as they were made aware of the incident and she was concerned about it but was relieved Resident #310 received her oxygen.	F 600			
F 641 SS=D	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 reviews and staff assessments the facility failed to accurately code a resident's Minimum Data Set for a diagnosis of vascular dementia for 1 of 6 residents reviewed for unnecessary medications (Resident #3). Findings included: Resident #3 was admitted to the facility on 09/03/14 with diagnoses which included type 2 diabetes, generalized muscle weakness, unsteady gait, lack of coordination, depression and a stroke. A Psychiatry note dated 03/13/19 revealed in part	F 641	1. Resident #3 Minimum Data Set (MDS) assessment did not include a diagnosis of vascular dementia which was documented in a psychiatry note dated 3/13/19. Resident #3's MDS assessment - Section I - was modified by Clinical Reimbursement Coordinator on 10/17/19. Resident #3's 2 diagnosis list was modified by the Clinical Reimbursement Manager on 11/1/19 to include vascular dementia. 2. The Center Reimbursement Manager shall audit MDS assessments Section I for all current resident who have had an assessment in the last 30 days to ensure all diagnosis' from psychiatry notes have	11/14/19	

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F 641	<p>Continued From page 25</p> <p>Resident #3 had a diagnosis of vascular dementia.</p> <p>An annual Minimum Data Set (MDS) dated 04/04/19 indicated Resident #3 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #3 required extensive assistance with activities of daily living except he was totally dependent on staff for toileting and he required supervision with eating. A review of active diagnoses revealed there was no diagnosis for vascular dementia.</p> <p>A quarterly Minimum Data Set (MDS) dated 10/04/19 indicated Resident #3 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #3 required extensive assistance with activities of daily living except he only required supervision with eating. A review of active diagnoses revealed there was no diagnosis for vascular dementia.</p> <p>An interview on 10/17/19 at 2:35 with MDS Coordinator #1 revealed it was an expectation when Nurse's read over the Psychiatry notes they should let MDS or Medical Records know if there was a new diagnosis so it could be added to the diagnoses list. She stated the diagnosis for vascular diagnosis had not been caught and therefore, had not been added to the list of diagnoses. She further stated they needed to be more careful to check consult notes to review for any new diagnosis and add them to the MDS.</p> <p>During a follow up interview on 10/17/19 at 4:04 PM MDS Coordinator #1 stated after review of Resident #3's medical record she was unsure why Psychiatry had given him a diagnosis of vascular dementia. She stated the diagnosis</p>	F 641	<p>been documented and updated on the diagnosis list.</p> <p>3. The Regional Reimbursement Manager shall educate the Center Reimbursement Coordinator and Medical Records on ensuring all diagnosis' from psychiatry notes are reviewed and any updates to a diagnosis list are made, and coding of Section I.</p> <p>4. Center Reimbursement Manager is responsible for implementing the acceptable plan of correction. The Center Nurse Executive and/or designee shall conduct random 5x's per week audit of MDS Section I to determine accuracy of psychiatric diagnosis which have been included in the psychiatric notes. Results of the audits to be brought to Quality Assurance Performance Improvement for review and recommendations.</p>	

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F 641	Continued From page 26 should have been caught after it was documented and they should have questioned Psychiatry for the reason of the diagnosis. She explained the Nurse Practitioner's wrote an order when a resident had a new diagnosis so it could be entered into the computer system and then they would pick it up to add to the MDS and they would have to talk with other consultants to remind them to utilize this process. An interview on 10/17/19 at 4:46 PM with the Director of Nursing she confirmed recently MDS Nurses were assigned to report to her. She stated it was her expectation if a consultant wrote a new diagnosis that an order should be written and entered so MDS would have the diagnosis to enter in to the MDS. She further stated they were planning to meet with Psychiatric practitioners to work on improving communication.	F 641			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Medical Director interviews, the facility failed to provide a scheduled dose of insulin prior to a meal as ordered for 1 of 3 residents reviewed for professional standards (Resident #210). The Findings Included: Resident #210 was admitted to the facility on	F 658	1. Resident #210 missed morning dose of insulin on 1/21/19 with no negative outcome. Resident #210 has been discharged from the facility. 2. All residents who are insulin dependent diabetics are at risk of missing a dose of insulin. 100% audit of all current insulin dependent residents was conducted by the Center Nurse Executive for the last 30	11/14/19	

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F 658	<p>Continued From page 27</p> <p>03/10/15 with diagnoses that included type II diabetes mellitus (insulin dependent). Resident #210 subsequently discharged from the facility on 07/12/19.</p> <p>A review of Resident #210's most recent quarterly Minimum Data Set Assessment dated 07/11/19 revealed Resident #210 to be cognitively intact. Resident #210 was coded as receiving insulin 7 of 7 days during the look back.</p> <p>A review of Resident #210's physician orders dated 11/21/18 revealed the following orders: Humalog Solution (insulin) - inject 14 units subcutaneously in the morning for Diabetes Mellitus before breakfast</p> <p>A review of Resident #210's Medication Administration Record (MAR) revealed she did not receive her scheduled dose of insulin before breakfast on 01/21/19 as it was marked "no, not given" or NN. Further review of Resident #210's MAR from 01/21/19 revealed her blood sugar was 272 before lunch.</p> <p>A review of the facility provided medication error log revealed on 01/21/19 there was a documented medication error involving Resident #210 on 01/21/19. Per the report Nurse #3 did not provide Resident #210 with her scheduled dose of insulin before her breakfast.</p> <p>During an interview with Nurse #3 by phone on 10/17/19 at 4:13 PM she reported 01/21/19 was her first day working with Resident #210. She stated she was not familiar with the residents in that part of the facility, was overwhelmed and did not know that there was a scheduled dose of insulin to be given to Resident #210 prior to her breakfast. She reported she was not aware of</p>	F 658	<p>days to ensure no other omitted dose of insulin had occurred and discrepancies resulted in physician notification and medication error report completed.</p> <p>3. The Center Nurse Executive and/or designee will educate licensed staff on the importance of following physician's orders with emphasis on ensuring all doses of insulin are given per physician order and care plan. New licensed staff and new agency licensed staff will be educated to this matter at orientation.</p> <p>4. The Center Nurse Executive and/or designee will conduct random 5x's per week audit of insulin orders to ensure all ordered insulin's are given as ordered. Results of the audits to be brought to QAPI for further review and recommendations.</p>	

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F 658	Continued From page 28 the missed dose until someone came to her and notified her of the missed insulin, though she could not remember who that person was. She reported when she was made aware of the missed dose, she checked Resident #210's blood sugar and dosed her insulin as ordered before her next meal (lunch). An interview with the Director of Nursing on 10/17/19 at 4:27 PM revealed she was not working in the building at the time the error took place, but it was her expectation that scheduled doses of insulin be given as ordered. She reported the nurse should have asked for assistance if she was behind and made sure all residents received their medications. During an interview with the Medical Director on 10/17/19, he reported he expected for nurses to provide scheduled medications as ordered but stated he did not feel one missed dose of insulin on 1/21/19 was harmful to Resident #210 as her next recorded blood sugar was 272. He stated if her blood sugar before her next scheduled dose of insulin at lunch was 400 or greater then he would have been concerned.	F 658			
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	F 689			11/14/19

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F 689	<p>Continued From page 29</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, resident and staff interviews the facility failed to secure a resident's smoking materials, specifically a cigarette lighter for 1 of 1 resident reviewed for safe smoking (Resident #52).</p> <p>The findings included:</p> <p>Review of the facility's Smoking policy with an effective date of 06/01/96 and revised on 06/15/17 read in part, "smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid etc.) will be labeled with the patients name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station." "If the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment." "Patients will not be allowed to maintain their own lighter, lighter fluid, or matches. "</p> <p>Resident #52 readmitted to the facility on 08/14/19 with diagnoses that included: acute respiratory failure, diabetes, major depressive disorder, and others.</p> <p>Review of the comprehensive Minimum Data Set (MDS) dated 08/21/19 revealed that Resident #52 was cognitively intact with no behaviors, rejection of care, or wandering. The MDS further revealed that Resident #52 required supervision of one person with ambulating on and off the unit. The</p>	F 689	<ol style="list-style-type: none"> 1. Resident #52 was assessed to be an independent smoker and signed a smoking evaluation dated 9/30/19. Resident #52 signed the evaluation that acknowledges the center's smoking rules and that the failure to comply with the smoking rules may result in termination of smoking privileges and/or initiation of a discharge plan. Resident acknowledged by keeping his lighter, he was breaking the smoking rules of the facility. Resident no longer has smoking materials on his person. 2. All other smokers are at risk for this deficient practice. The Center Executive Director and/or designee will conduct a 100% review of current independent smokers to ensure they do not have lighters on their person. 3. The Center Executive Director and/or designee will re-educate all independent smokers of the smoking rules they have signed and the importance of following the plan for the safety of the entire facility. Additionally, independent smokers will be educated on further non-compliance leading to all smokers being supervised. Licensed staff will be educated on ensuring lighters are returned once the smoker has finished smoking. 4. The Center Executive Director and/or designee shall conduct random 5x's per week audit of lighters of independent smokers to determine compliance. 	

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F 689	<p>Continued From page 30</p> <p>MDS also indicated that Resident #52 used tobacco during the assessment reference period.</p> <p>Review of a facility document titled Smoking Evaluation and dated 09/30/19 indicated that Resident #52 was assessed as an independent smoker. The evaluation further read, "I understand that by my signature, I am acknowledging the center's smoking policy and the outcome of my smoking evaluation. I further understand that failure to comply with the smoking rules may result in termination of my smoking privileges and/or initiation of a discharge plan." The form was signed by Resident #52 and Unit Manger (UM) #1.</p> <p>An observation and interview were conducted with Resident #52 on 10/14/19 at 11:40 AM. Resident #52 was resting in bed with eyes open. He had a flat affect but was alert and verbal. He reported that he was able to go outside and smoke anytime he wanted to. He also indicated he had signed a paper about the smoking policy and procedures. Resident #52 stated that he kept his cigarettes and lighter in the seat of his walker. He added "the staff is supposed to be keep my lighter, but I can't ever find them when I want to go outside." He added "but I do not want to get in trouble." Resident #52 indicated he had kept his lighter since he had decided to continue smoking and was reassessed by the staff on 09/30/19.</p> <p>An observation of Resident #52 was made on 10/15/19 at 4:04 PM. Resident #52 was outside in the smoking area and was observed to be smoking a cigarette. When he was finished smoking Resident #52 was observed to lift the seat of his walker and place his cigarette pack and a lighter that was covered with white tape in</p>	F 689	Results of the audits to be brought to Quality Assessment Performance Improvement for further review and recommendations.		

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F 689	<p>Continued From page 31</p> <p>the seat and close then lid. Resident #52 then ambulated with his rolling walker out of the smoking area into the facility and down to his room. He did not stop at the nurse's station and or at the nurses medication cart and turn in his smoking material. Resident #52 returned to his room placed his rolling walker beside the bed and laid down on the bed.</p> <p>An interview was conducted with UM #1 on 10/16/19 at 4:16 PM. UM #1 stated that all smokers were assessed and if they were assessed to be independent then they were able to go and smoke as often as they wished but they must get their smoking material (cigarettes and lighter) from the nurse on the hall. He further stated that once the resident was done smoking, they should return their smoking materials back to the nurse on the medication cart and they would be secured. UM #1 stated that there was always someone at the nurse's station who could obtain their smoking material when they wanted to go out, if the nurse on the medication cart was busy. He added that if a resident did not turn in their smoking material, they may lose their privileges because they sign the facility's policy understanding the rules. UM #1 stated that he had assessed Resident #52 on 09/30/19 and he was a safe smoker and was able to go out as often as he wished. UM #1 stated that to his knowledge Resident #52 was following the rules and turning in his smoking material.</p> <p>An interview was conducted with Nurse #1 on 10/17/19 at 10:52 AM. Nurse #1 indicated that she was very new to the facility but was working on the unit with Resident #52 today. She stated that she had not ever given Resident #52 his cigarettes or lighter and he had never turned</p>	F 689		

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F 689	<p>Continued From page 32</p> <p>them into her. She proceeded to open her medication cart and no cigarettes were found. There were 2 lighters in the top left drawer one grey and one blue but contained no name.</p> <p>An interview was conducted with the Unit Secretary (US) on 10/17/19 at 10:51 AM. The US stated she was responsible for managing the nurse's station and she had not ever given Resident #52 his smoking material nor had he turned them into her. The US stated that he would generally get those from his nurse.</p> <p>An observation and interview were conducted with Resident #52 on 10/17/19 at 10:51 AM. He was resting in bed and was alert and oriented but continued to have a flat affect. He stated he had been outside to smoke earlier in the day and commented on the weather. He stated that his cigarettes and lighter remained in the seat of his walker. With Resident #52's permission the lid of his rolling walker was lifted and there were 2 red packs of cigarettes and a lighter that had been covered in white tape. Resident #52 stated that he kept his smoking material because he could not ever find the staff when he wanted to go out and smoke.</p> <p>An observation of Resident #52 was made on 10/17/19 at 11:07 AM. Resident #52 got out of bed and put his jacket on and grabbed his rolling walker and ambulated out of his room to the exit door to the facility. He exited the facility to the smoking area and sat down. He was observed to open the lid of his rolling walker and pull out a pack of cigarettes and a lighter and proceed to light and smoke a cigarette. When Resident #52 had finished the cigarette, he put the cigarette out and grabbed his rolling walker and ambulated</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
NAME OF PROVIDER OR SUPPLIER MOORESVILLE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
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F 689	Continued From page 33 back in the facility and to his room. He did not stop and turn in his smoking material and once in his room returned his rolling walker to the end of his bed and laid down. An interview was conducted with Nurse #2 on 10/17/19 at 11:10 AM. Nurse #2 stated that she worked with Resident #52 and was familiar with him. She stated that he was able to go out and smoke as he wished but had to obtain his lighter from the nurse on the hall. Nurse #2 stated that Resident #52 usually came to her every hour to get his lighter and stated today he must have gotten it from Nurse #1. She continued to say that residents were not able to keep their lighters on them even if they asked, we have to tell them no. To her knowledge Resident #52 did not have his smoking materials on him and they had been turned into Nurse #1. An interview was conducted with the Director of Nursing (DON) and Administrator on 10/17/19 at 12:57 PM. The DON stated that each resident that wanted to smoke or was a smoker was assessed on admission and regularly thereafter. She stated that Resident #52 was an independent smoker and could go out as often as he wished but he had to turn his smoking material into the nurse on the unit. The DON and Administrator stated that they were unaware that Resident #52 had a lighter in his walker and that they would expect him to turn the lighter into the nurse on the hall and the staff should be aware of when they give it to him and should make sure it was turned back in to them.	F 689			