STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	403 CRESTVIEW AVENUE WILSON, NC 27893

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E 000	Initial Comments An unannounced recertification survey was conducted on 08/23/21 through 08/27/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #57Q611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/23/21through 08/27/21. Event ID# 57Q611. Zero of the 6 complaint allegations were substantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		9/29/21

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

Electronically Signed | 09/24/2021

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 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews with staff, resident, and physician, and record review the facility failed to notify physician when scheduled medications were not administered to one of one resident reviewed for notification of change. (Resident #78). Findings included: Resident #78 was admitted to facility on 07/31/21 with diagnoses that included myocardial infarction (heart attack), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF),	F 580	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Wilson Pines Nursing and Rehabilitation Center's response to this Statement of	

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F 580	Continued From page 2 respiratory failure, and chronic pain of hips and legs. A physician order dated 07/31/21 for Atorvastatin Calcium (lower cholesterol) tablet 80 mg give 1 tablet by mouth one time a day. A physician order dated 07/31/21 for Trazadone HCl (sleep aid) tablet 50 mg, give 50 mg by mouth at bedtime. A physician order dated 07/31/21 for Carvedilol (heart failure and blood pressure) tablet 12.5 mg, give 12.5 mg by mouth two times a day. A physician order dated 07/31/21 for Entresto (heart failure) tablet 49-51mg, give one table by mouth two times a day. A physician order dated 08/05/21 for Oxycodone HCl (pain management) 5 mg, give 1 tablet by mouth three times a day. A physician order dated 08/11/21 for Ascorbic Acid (supplement to promote wound healing) 500 mg, give 1 tablet by mouth two times a day. A physician order dated 08/13/21 for Famotidine (decrease stomach acid) 20 mg give one tablet at bedtime. The most recent admission Minimum Data Set (MDS) dated 08/07/21 revealed Resident #78 was cognitively intact. During an interview on 08/23/21 at 11:31 AM Resident #78 revealed that when she returned to facility at 10:37 PM from a day out with family on 08/21/21 she requested from Nurse #2 her	F 580	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceed. F580 Notification of change Nurse Practitioner made aware of resident # 78 not receiving medications on 8/25/21 by the Quality Assurance Nurse. On 9/17/21 100% Audit for Medication not administered due to Leave of Absence completed by the Quality Assurance Nurse to ensure Physician or Nurse Practitioner were notified of any residents who did not receive scheduled medications. The Resource Nurse will notify Nurse Practitioner or Physician of all areas of concern with documentation in the medical record. On 8/25/21 the Staff Facilitator initiated a 100% in-service with Medication Aides and Nurses regarding releasing Therapeutic leave of Absence medications. When resident returns to facility and scheduled medications are missed, notify the physician for further orders. Medication aide must communicate with nurses when resident is leaving or returning to the facility. Inservice will be completed by 9/29/21. All	

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F 580	Continued From page 3 medications that were scheduled for the evening to be given. She reported that she was told by the Nurse #2 that she returned too late to receive medications. Resident #78 did not receive her scheduled medications that evening. Record review of Medication Administration Record (MAR) revealed on 08/21/21 Resident #78 did not receive medications scheduled to be administered between 08:00 PM and 09:30 PM. The medications not administered included Atorvastatin, Trazadone, Carvedilol, Entresto, Oxycodone, Ascorbic acid, and Famotidine. The chart code documented by Nurse #2 for the medications that were not administered was #3-absent from facility. During an interview on 08/25/21 at 10:32 AM Nurse #1 revealed that Resident #78 signed out of the facility at 11:10 AM on 08/21/21 to spend day with sister. She stated that Nurse #2 reported on 08/22/21 at the 07:00 AM shift report that Resident #78 did not return to the facility until late and was not given her scheduled medications for the evening shift on 08/21/21. During a phone interview on 08/25/21 at 10:42 AM Nurse #2 revealed Resident #78 was expected to return to facility at 09:00 PM. She stated that Resident #78 had not returned to the facility and at 10:00 PM she made a call to the family and left message regarding return. Nurse #2 reported that Resident #78 returned to facility at approximately 10:50 PM. Nurse #2 confirmed that Resident #78 did not receive her medications that evening because she was not in the facility when the medications were scheduled to be administered. She stated that she did not notify the physician of medications not administered or	F 580	newly Hired medication aides and nurses will be in-serviced during orientation in regards to Therapy Leave Medications. Medication not administered due to Leave of Absence will be printed, discussed, and investigated ensuring the Nurse Practitioner or Physician are notified of any medication not administered due to leave of absence with documentation in the medication record in Cardinal IDT by the Director of Nursing, Resource Nurses, Quality Assurance Nurses, RN Supervisor or MDS Nurses weekly x 4 weeks. Then Monthly x 1 month. All areas of concern will be addressed at that time by the Director of Nursing, Resource Nurses, Quality Assurance Nurse, RN Supervisor or MDS Nurses. The Director of Nursing will present the findings to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the findings to determine any issues that may need further interventions put into place and to determine the need for further monitoring.	

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F 580	Continued From page 4 to obtain permission to administer the medications late to Resident #78 upon return to facility. Nurse #2 was unable to state why she did not notify the physician about the medications that were not administered for Resident #78. During an interview on 08/25/21 at 11:07 AM the Quality Assurance Nurse revealed that the physician should have been called regarding medications not being administered. During an interview on 08/25/21 at 11:17 AM the Assistant Director of Nursing (ADON) revealed that nurses are educated to notify the physician when medications are not administered. The ADON stated that the physician could have given permission for medications to be administered late. During an interview on 08/25/21 at 02:38 PM Family Nurse Practitioner (FNP) revealed that she was notified today that Resident #78 went out with family on 08/21/21 and medications were not administered. FNP stated that she would have preferred that nursing contacted provider to have the medication administered when Resident #78 returned. FNP reported that the facility staff can contact them regarding resident at any time. During an interview on 8/27/21 at 3:48 PM Medical Director revealed that Nurse #2 should have contacted provider regarding Resident #78's missed medications when returning to facility from LOA. Medical Director reported that the office has an on-call system and can be reached at any time.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/29/21

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F 641	Continued From page 5 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the admission Minimum Data Set (MDS) for 1 of 18 residents (Resident #30) reviewed for accuracy of MDS. The findings included: Resident #30 was admitted to the facility 6/30/21 with diagnoses that included cerebral infarct (a stroke) and essential hypertension (high blood pressure). The Care Plan dated 7/7/21 indicated Resident #30 was a safe and independent smoker. The admission MDS for Resident #30 dated 7/12/21 did not indicate she used tobacco products. Interview on 8/24/21 at 10:51 AM with Resident #30 revealed she usually goes out to smoke at least twice a day since she has resided in the facility. During an interview on 8/25/21 at 9:43 AM, the MDS Coordinator stated Resident #30 was a smoker and the admission MDS had been coded incorrectly. During an interview on 8/26/21 at 1:24 PM, with the Assistant Director of Nursing (ADON) revealed she was familiar with Resident #30. She further stated Resident #30 was a smoker. She	F 641	F641 Accuracy of Assessment The Minimum Data Set (MDS) assessment for resident #30 was modified by the Minimum Data Set nurse on 8/25/2021 to reflect current tobacco use. 100% audit of all current resident most current MDS assessment was initiated on 8/25/2021 by the Director of Nursing (DON) utilizing a MDS Accuracy Audit tool to ensure all completed MDS's were accurately coded to reflect current tobacco use. Any identified areas of concerns were corrected to include modifications by the MDS Nurses during the audit. Audit completed on 9/29/2021. On 9/17/2021 an in-service was initiated by the Facility Consultant with the MDS Coordinator and MDS Nurse regarding accurately coding the MDS, to reflect current tobacco use. In-Service to be completed by 9/29/2021. 10% of completed MDS's, will be reviewed by the DON to ensure all MDS's are accurately coded to reflect current tobacco use utilizing an MDS Accuracy QA Tool weekly for 4 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the DON to include additional training and modifications to assessment as indicated. The Administrator will review and initial the MDS Accuracy QA Tool weekly for 4	

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F 641	Continued From page 6 stated the MDS should have been coded to indicate Resident #30 was a smoker. During an interview on 8/26/21 at 2:13 PM, the Administrator stated the MDS should be accurate. He further stated that anytime a MDS is coded wrong it should be corrected and resubmitted.	F 641	weeks and then monthly for 1 month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QA Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months to review the MDS Accuracy QA 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.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		9/29/21

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F 656	Continued From page 7 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, observation, and record review, the facility failed to implement the care plan for one of two residents reviewed for bed positioning (Resident #16) and one of six residents reviewed for smoking (Resident #78). The findings included: 1. Resident #16 was admitted to the facility on 01/13/20 with diagnoses that included stroke, right sided weakness, and difficulty speaking. A quarterly Minimum Data Set (MDS) dated 06/15/21 indicated Resident #16 had severe cognitive impairment and required extensive assistance with bed mobility and activities of daily	F 656	F656 Develop/Implement Comprehensive Careplan Resident #16 bed was put in lowest position per care plan on 8/26/21 by Quality Assurance Nurse. Resident #78 smoking assessment was completed, and care plan updated to reflect smoking status on 8/24/21 by Quality Assurance Nurse. A 100% audit of all residents that require bed positioning were observed by the Quality Assurance and Director of Nursing on 9/17/21to ensure care plan interventions for bed positioning were implemented and maintained. There were no identified areas of concern during the audit.	

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F 656	Continued From page 8 living. No falls since the previous assessment were noted. Review of the Care Plan indicated Resident #16 was at risk for fall due to weakness with an intervention for the bed to be in the lowest position. On 08/23/21 at 10:45 AM an observation was made of Resident #16 sleeping in bed in a high position. On 08/23/21 at 3:00 PM an observation was made of Resident #16 sleeping in bed in a high position. On 08/24/21 at 9:15 AM an observation was made of Resident #16 sleeping in bed in a high position. On 08/25/21 at 3:50 PM and observation was made of Resident #16 sleeping in bed in a high position. During an interview on 08/25/21 at 4:00 PM, Nurse Aid (NA) #7 confirmed the bed was not in the lowest position. NA #7 then demonstrated the low position by putting the bed all the way down to the floor. NA #7 revealed bed positioning instruction were found in the resident's care guide. During an interview on 08/25/21 at 4:05 PM, Resident #16 stated she was okay with having her bed in the lowest position. During an interview 08/26/21 at 10:00 AM, Nurse #5 revealed Resident #16 had a recent fall from bed with an intervention to place bumpers on	F 656	A 100% audit of all residents that smoke to include resident # 78, care plans were reviewed on ¬¬-8/25/21 by the Director of Nursing (DON), to ensure the care plan reflect smoking safety. Any care plans with areas of concerns were updated by the MDS Nurse by 8/25/21 with oversight from the Director of Nursing, to reflect smoking safety. An in-service was initiated on 9/17/21 by the Registered Nurse Supervisor with all nurses and nursing assistants regarding how to access the resident care plan and following care plan interventions. All newly hired nurses and nursing assistants will receive the in-service by the Staff Facilitator or Registered Nurse Supervisor during orientation. Inservice will be completed 9/29/21. An in-service was initiated on 9/17/21 by the Director of Nursing with the interdisciplinary care plan team members: Minimum Data Set (MDS) Coordinator, Dietary Manager (DM), Social Worker (SW), Staff Facilitator, Quality Improvement Nurse and Activities Director on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed. Inservice will be completed 9/29/21. All newly hired Minimum Data Set (MDS) Coordinator, Dietary Manager (DM), Social Worker (SW), Staff Facilitator, Quality Improvement Nurse and Activities Director will be in-serviced during orientation in regards to Comprehensive Care Plans.	

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F 656	Continued From page 9 bed. Resident #16 declined to have the bumpers placed on her bed and staff were educated on keeping her bed in the lowest position. Nurse #5 further stated Resident #16 had not had any further falls. During an interview 08/26/21 at 3:00 PM, the Administrator revealed staff should be using the Care Guide to implement fall interventions. 2. Resident #78 was admitted on 07/31/21 with diagnoses that included myocardial infarction (heart attack), chronic obstructive pulmonary disease (COPD), and respiratory failure. The admission Minimum Data Set (MDS) dated 08/07/21 revealed Resident #78 was cognitively intact, required oxygen, and did not indicate current tobacco use. During Resident #78's record review, no smoking evaluation assessment was observed. Review of Resident #78's care plans revealed no care plan for smoking safety. During an interview on 08/23/21 at 10:44 am Resident #78 reported she had begun smoking when she was removed from isolation. She stated she was given a smoking safety apron to use and was able to smoke independently throughout the day until the door locked at 8:00 pm. During an interview on 8/25/21 at 11:38 am the Assistant Director of Nursing (ADON) reported that resident admissions and care plans are	F 656	The Quality Assurance Nurse will observe 10% of residents with bed positioning requirements to include resident #16 to ensure care plan interventions for bed positioning are implemented and maintained weekly x 4 weeks then monthly x 1 month utilizing the Bed Positioning Audit Tool. The Quality Assurance Nurse will address all concerns identified during the audit. The Administrator or Director of Nursing will review and initial the Bed Positioning Audit Tool weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. An audit will be completed of 10% of all resident's that smoke care plans to ensure the care plan reflect smoking safety weekly x 4 weeks then monthly x 1 month by the Director of Nursing to ensure that the care plans accurately reflect the residents utilizing the Care Plan Audit Tool. The Quality Assurance Nurse will address all concerns identified during the audit. The Administrator will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will present the findings of the Bed Positioning Audit Tool and The Careplan Audit tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Bed Positioning Audit Tool and the Careplan Audit tool to determine trends and/or issues that may need	

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F 656	Continued From page 10 completed by the administrative nursing team and updated when changes occurred. During an interview on 08/25/21 at 12:00 pm Nurse #7 revealed when Resident #78 was admitted she had been on isolation until 08/16/21 and was not allowed to smoke while on isolation. Nurse #7 stated any administrative nurse could complete resident smoke evaluation and update care plan.	F 656	further interventions put into place and to determine the need for further frequency of monitoring	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to implement effective interventions to prevent the possibility of a resident smoking in his room for 1 of 6 residents (Resident #50) and failed to complete a smoking evaluation for one of six residents (Resident #78) reviewed for smoking. (KK will have example #2) Findings included: Example #1 A review of the facilities smoking policy titled "Smoking Policy" effective on 1/09 and revised 02/01/18 read in part, Smoking is not allowed inside of this facility,	F 689	F689 Free of Accident Hazards/Supervision/Devices Smoking assessment was completed on resident #50 and #78 on 8/27/2021 by Quality Assurance nurse (QA). Smoking assessments were updated on all residents who smoke on 8/27/2021 by Quality Assurance nurse (QA). 100% room audit of residents identified as smokers or desires to smoke was completed on 8/25/2021 and 8/26/2021 by the Resource Nurse to identify any resident with smoke paraphernalia in	9/29/21

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under any circumstances, at any time by any individuals to include residents, visitors, or staff.

Smoking is prohibited in any areas of this facility where flammable liquids, combustible gases or oxygen are in use or stored in and in any other hazardous location identified by no smoking signage.

All resident smoking materials are maintained in a secure area and are accessible only through the assistance of the facility's staff.

Resident #50 was admitted to the facility on 03/05/20 and readmitted 11/06/20 with the diagnosis which included Major Depressive Disorder.

The facility smoking policy titled " Smoking Policy" was reviewed and signed by Resident #50 on 7/19/21

Resident #50 Quarterly Minimum Data Set (MDS) dated 7/22/21 revealed Resident #50 was cognitively intact, required extensive and two people assist with bed mobility, mechanical lift with transfers. He used a wheelchair for mobility. The MDS revealed he had no behaviors

Record review of Resident # 50 July physician orders revealed he had no oxygen ordered.

A review of Resident #50 Titled, "Safe Smoking Evaluation" assessment form completed on 07/20/21 and on 8/24/21 revealed he was a safe smoker and may smoke independently.

An interview on 08/26/21 at 9:52 AM Nurse #8, revealed she completed the smoking evaluations for Resident #50 on 07/20/21 she reported that Resident #50 was evaluated as an independent

room. There were no concerns identified.

On 8/26/2021, all alert and oriented residents identified as smokers were educated by the Quality Assurance nurse (QA), Treatment nurse, and Medication aide (MA) regarding the smoking policy, securing smoke paraphernalia and safe smoking.

On 8/26/2021 100% in- service was initiated by the Staff Development Coordinator for all nursing staff regarding asking and retrieving smoking paraphernalia immediately after residents return from the smoke area and completion of smoking assessments. In-service will be completed by 8/29/19. All newly hired nurses will be in-serviced during orientation in regards to Smoke Paraphernalia and completion of smoking assessments.

10% audit of smoking resident rooms will be completed by the Quality Improvement nurse to ensure smoking paraphernalia is not stored in resident rooms to include resident #50 and #78 utilizing the Smoking Paraphernalia Audit Tool weekly x 4 weeks, then monthly x 1 month.

10% audit of smoking residents charts will be completed by the Quality Assurance Nurse for completion of smoking assessments to include resident #50 and resident #78 utilizing the Smoking Paraphernalia Audit tool which includes smoking assessment completion, weekly x 4 weeks and then monthly x 1 month.

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F 689	Continued From page 12 safe smoker. Review of care plan dated 07/23/21 revealed Resident #50 was care planned to smoke independently with a goal to smoke in the designated smoking area and smoke safely. Staff was responsible to obtain and store smoking supplies and observe smoking was safe and to retrieve smoking supplies once smoking was completed. An interview on 08/26/21 at 10:05 AM with Nurse aid (NA) # 1, stated on 7/25/21 she saw smoke was coming from Resident #50 room and when she entered, she observed that he had a "blunt" like cigarette in his hand. She also reported that she removed the smoking materials from Resident #50 and notified Nurse #1. NA#1 indicated Resident #50 had several episodes when he was impatient with staff when he wanted to smoke. She stated that Resident #50 cursed and yelled at staff when he had to wait on staff assistance to get out of bed so he can go smoke. Review of Nurse #1 note dated 07/25/21 revealed Resident #50 had a "blunt" (a small cigar) cigarette in his room that he denied he had smoked. Nurse #1 observed ashes on a soda can and smelled a lingering odor of smoke in the room. She confiscated the lighter and cigarette, educated Resident #50 on dangers of smoking in the facility and notified the Administrator and Physician. An interview on 08/26/21 at 9:03 AM Nurse #1, stated on 7/25/21 she was notified by NA#1 that Resident #50 was found with a "blunt" like cigarette in his room and had the odor of smoke. She revealed that Resident #50 lit a cigarette in	F 689	Director of Nursing will review and initial the Smoking Paraphernalia Audit Tool which includes smoking assessment completion weekly x 4 weeks then monthly x 1 month to assure all areas of concern were addressed. The Administrator will forward the results of the Smoking Paraphernalia Audit Tool which includes smoking assessment completion, to the Executive QA Committee monthly x 2 months for review 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.	

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his room because he wanted to go outside and his NA was in another room, he was frustrated with having to wait. Nurse #1 reported she removed the lighter and cigarette, educated Resident #50. She stated she completed an incident report, documented in a progress note, and notified the Administrator and Physician of the incident.

A record review of the facility room assignment by census dated 7/25/21 revealed Resident #50 had no roommate.

During an observation on 08/24/21 at 10:21 AM Resident #50 had a cigarette and lighter at his bedside, there was no odor of smoke or ashes in his room. During an interview Resident #50 indicated he had not had a roommate for a long time, and he did not smoke in his room. He had kept the cigarette and lighter in his coat pocket because staff had lost several of his lighters. Observation of the room revealed Resident #50 had no roommate and no oxygen was stored in the room.

An interview on 08/24/21 at 10:39 AM NA#1, revealed that Resident #50 was not allowed to keep smoking materials in his room. She revealed she did not know how Resident #50 had obtained the cigarette and lighter today, and she had removed the cigarette and lighter and reported to the nurse. She revealed residents requested smoking materials prior to smoking and returned the materials to staff when they were finished. All smoking materials were kept in the medication cart.

An interview on 08/26/21 at 9:52 AM Nurse #8, revealed she completed the smoking evaluation

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for Resident #50 on 8/24/21 and stated that Resident #50 was evaluated as an independent safe smoker.

An interview on 8/26/21 at 11:50 AM with Admission Coordinator, revealed that all residents are educated on the smoking policy on admission. She revealed that Resident #50 was re-educated on the smoking policy for the facility and was signed by Resident #50 on 7/19/21.

An interview on 08/26/21 at 2:49 PM with the facility Administrator revealed that all residents smoked in designated smoking area and all residents were safe smokers. He stated that smoking materials were locked in the medication cart after smoking. The Administrator revealed that a smoking evaluation were completed on all residents monthly. Resident #50 was reported for smoking in the room on 7/25/21, and he was told either a 30-day notice of discharge or revoked smoking privileges would result with any other smoking incident. The Administrator indicted he had no accident/ incident report on file for 7/25/21 of Resident #50 smoking in his room, the nurse was mistaken. When asked about the cigarette and lighter observed in Resident #50 possession on the morning of 08/24/21, he stated he was unsure how Resident #50 obtained the smoking materials and may have "bummed" (begged for) the materials from another resident.

2. Resident #78 was admitted to the facility on 07/31/21 with diagnoses that included myocardial infarction (heart attack), chronic obstructive

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pulmonary disease (COPD), and respiratory failure.

Resident #78 ' s admission Minimum Data Set (MDS) dated 08/07/21 revealed she was cognitively intact and required oxygen. The assessment did not indicate current tobacco use.

Resident #78 ' s care plan initiated on 08/01/21 and updated on 08/11/21, 08/12/21 and 08/17/21 revealed that Resident #78 did not have a care plan for smoking.

Record review revealed that Resident #78 did not have a smoking safety evaluation completed.

Resident #78 was observed returning from the facility' s smoking area on 08/23/21 at 10:44 AM with smoking apron in place and smoking materials on right side of wheelchair seat. The resident entered her room with smoking materials and placed the items in her bedside table.

During an interview on 08/23/21 at 10:44 AM Resident #78 revealed that she had been smoking since being removed from isolation. Resident #78 reported that she was provided a smoke apron and was able to smoke independently in the smoke area until 8:00 PM when the door was locked.

On 08/24/21 at 10:34 AM Resident #78 was observed returning from the facility ' s smoking area with smoking materials and entered her room without returning smoking materials to nurse.

On 08/24/21 at 12:12 PM Nurse #9 was observed leaving Resident #78' s room with smoking

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materials and handed the smoking materials to Nurse #1.

During an interview on 08/24/21 at 12:12 PM Nurse #9 revealed that residents were assessed for smoking when admitted and provided education regarding storing smoking materials. She reported that Resident #78' s smoking materials should be stored in the top drawer of the medication cart on the unit.

During an interview on 08/25/21 at 11:38 AM the Assistant Director of Nursing (ADON) revealed that nurses were educated on the facility ' s smoking policy including assessment and storage of smoking materials.

During an interview on 08/25/21 at 12:00 PM Nurse #7 revealed that any administrative nurse was able to complete smoking safety evaluations and update care plans. Nurse #7 stated that Resident #78 ' s smoking safety evaluation should have been done after completion of isolation if nursing was aware of smoking. She reported that she would not know that Resident #78 was a smoker unless notified by nursing. Nurse #7 stated that Resident #78 was removed from isolation on 08/16/21.

During an interview on 08/25/21 at 12:10 PM Nurse #8 revealed that newly admitted residents, who are identified as smokers, are evaluated for safety. The nurse reported that part of the facility ' s evaluation is for a staff member to observe a resident as they smoke to assure they do it safely. She further reported that a smoker, who is evaluated to be safe, would then be able to smoke independently. Nurse #8 stated that smoking materials are secured in the medication

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F 689	Continued From page 17 cart and independent smokers were able to request materials and return when the resident finished smoking.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to contain topical medications in 1 of 1 resident's room (Resident #18) and failed to discard expired medications in 1 of 2 medication rooms	F 761	F761 Label/Store Drugs and biologicals On 8/26/2021 Resource nurse removed the expired Calcium from the 100-hall medication room.	9/29/21

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F 761	Continued From page 18 (medication room #1). The findings included: 1 a. Resident #18 was admitted to the facility 12/06/19 with diagnoses that included stroke with left sided weakness and kidney disease. A quarterly Minimum Data Set (MDS) dated 06/15/21 indicated Resident #18 was cognately intact and was independent with activities of daily living. Review of Resident #18's Care Plan indicated an ulcer to right toe with interventions treat as ordered and evaluate and assess weekly for changes. An observation was made 8/23/21 at 11:30 AM of a prescription topical ointment, balsam peru and castor oil, on Resident #18's dresser. A bottle of menthol and spearmint herbal gel with "veterinary" in the name and a picture of a horse on the label was also observed. The label stated, "for animal use only." Record review on 08/23/21 revealed Resident #18 did not have a Medication Self Administration Assessment or order to self-administer. During an interview on 8/23/21 at 11:30 AM, Resident #18 revealed the balsam peru ointment was given to her at a recent hospitalization for a sore bottom due to diarrhea. The menthol gel was brought by a family member and was used for shoulder pain. Resident #18 indicated she was unsure if staff was aware she had the items in her room. During an interview on 8/23/21 at 12:00 PM, Nurse #3 indicated residents were not supposed	F 761	On 8/25/2021, Minimum Data Set nurse completed a medication self-administration assessment on Resident #18, and it was determined that Resident # 18 was able to self-administer medication. On 8/25/2021, Minimum Data Set nurse obtained a physician order for resident # 18 to keep Veterinary Liniment Gel at bedside. On 8/25/2021, Minimum Data Set Nurse updated Resident #18 care plan to reflect self-medication administration and to keep medication at bedside. On 8/25/2021, Minimum Data Set Nurse provided Resident # 18 with a lock box to store medication in at bedside. On 8/26/2021, 100% audit of all medication rooms to include the 100-hall medication room was completed by the Quality Assurance Nurse. The audit is to ensure no expired medications to include calcium were stored in the medication rooms. The Clinic Coordinator, Staff Facilitator, and QA nurse addressed all concerns identified during audit to include removal of the expired medication and reordering per policy On 8/26/21, 100% audit of all resident rooms to include resident # 18 was completed by the Quality Assurance Nurse. This audit is to ensure that no resident is storing medication at bedside without a physician order, medication self-administration assessment, lock box for medication storage and care planned for medications at bedside. The Resource Nurses will address all concerns identified during the audit to include obtaining a physician□s order to keep medications at	

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F 761	Continued From page 19 to have any medications or topical cream at bedside. She further stated staff should try their best to remove it and get a doctor's order for the product or something similar. During an interview on 08/26/21 at 1:30 PM, the Nurse Practitioner (NP) indicated the menthol gel was safe for humans and she was unaware of any potential side effects from use. The NP was aware the label stated "for animal use only" but stated it was safe for humans to use. The NP further stated Resident #18 was safe to keep medication in her room and she was not aware of any residents on Resident #18's hall that were at risk of ingesting the gel if found. During an interview on 8/26/21 at 2:00 PM, the MDS Coordinator revealed the products were now kept in a lock box in Resident #18's room. She indicated if it had been brought to the nurse supervisor's attention, staff would have completed a Medication Self Administration Assessment and gotten an order from the doctor. During an interview on 8/26/21 at 3:00 PM, the Administrator revealed the products should have been discarded or removed when discovered in Resident #18's room. 2. An observation and interview on 8/26/2021 at 10:08 AM of medication storage room #1 with Nurse #9 revealed 3 bottles of Calcium 250 mg = D3 (over-the counter-supplement) with the expiration date of 6/2021 stamped on each bottle. Nurse #9 verified the bottles were expired and she discarded them into the medication tote to be returned to the pharmacy. Nurse #9 revealed she checked the medication room weekly for expired medications and returned any expired	F 761	bedside, completing medication self-administration assessment, providing a lock box for medication storage, and updating care plan to include storing medications at bedside. 100% in-service was initiated on 8/26/2021 by the Staff Development Coordinator with all nurses regarding Expired Medications and Residents storing medication at bedside. This in-service emphasis was on (1) checking medications prior to administration for expired dates (2) appropriately discarding expired medications per pharmacy policy. (3) obtaining a physician□s order to keep medications at bedside. (4) completing medication self-administration assessment. (5) Providing a lock box for medication storage at bedside. (6) Updating care plans for medications at bedside. In-service will be completed by 9/29/2021 All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regard to Medication Storage. All medication rooms will be audited by the Resource Nurses 1 times a week x 4 weeks utilizing the Medication Audit Tool. This audit is to ensure no expired medications were stored in the medication rooms. The nurse will be immediately re-trained by the Resource Nurses for any identified areas of concern. The Director of Nursing will review and initial the Medication Audit Tool weekly x 4 weeks to ensure all areas of concerns were addressed.	

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F 761	Continued From page 20 medications to the pharmacy. She indicated she read the 06/2021 as 09/2021 on the bottles of Calcium 250m = D3. During an interview on 8/26/2021 at 2:00 PM the Assistant Director of Nursing (ADON) indicated the nurses were instructed to check medication carts and medication rooms routinely for expired medications and remove them from use An interview on 8/26/2021 at 3:13 PM Administrator revealed nursing staff checked medication rooms for expired medications, discarded any expired medications into the medication tote, and sent them back to the pharmacy.	F 761	10% of all resident rooms will be audited by the Resource Nurses weekly x 4 weeks utilizing the Self Administer Medication Audit Tool. This audit is to ensure that no resident is storing medications at the beside without physician□s order, medication self-administration assessment, a lock box for medication storage at bedside and updating care plans for medications at bedside. The Nurse/Resident will be immediately re-trained by the Resource Nurse for any identified areas of concern. The Director of Nursing will review and initial the Self Administer Medication Audit Tool weekly x 4 weeks to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Medication Audit Tool and the Self Administer Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 month and review the Medication Audit Tool and Self Administer Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further 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 -	F 812		9/29/21

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F 812	Continued From page 21 §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 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 and chemical company technician interviews, the facility failed to maintain sanitary conditions in the kitchen by: 1. failing to ensure the dishwasher was rinsing dishes at the correct temperature to sanitize the dishes; 2. by failing to discard expired food and to date opened resealable food items stored in the walk-in refrigerator; 3. by not properly storing and dating open dry food items; and by failing to store food items off the floor. These practices had the potential to affect all residents. Findings included: 1. Observation of the single conveyer dual temperature dishwasher on 8/23/21 at 10:34 AM revealed an initial wash temperature of 150 degrees Fahrenheit (F) and a final rinse temperature of 138 degrees F. Subsequent observation at 10:50 AM revealed a wash temperature of 163 degrees F and a final rinse	F 812	F812 Procurement, store/prepare/serve-sanitary On 8/26/2021, the Spartan Chemicals Company converted the facility dish machine to any temperature chemical combination for low temperature machine. The chemicals are Sparclean Rinse Aid, Sparclean Detergent and Chlorinated Sanitizer. On 8/23/21, the Dietary Manager removed stored items on floor and discarded all opened and unlabeled food not labeled when opened per facility protocol. On 8/23/2021, the Administrator completed an audit of all opened items in the walk-in refrigerator and dry storage to ensure all items labeled with a use by date when opened per facility protocol. The Dietary Manager addressed all concerns identified during the audit to include discarding all items not labeled	

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	345372	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 812	Continued From page 22 temperature of 136 degrees F. Interview on 8/23/21 at 10:50 AM with the Dietary Manager (DM) revealed she was unsure of what the temperature should be to sanitize the dishes. Interview on 8/25/21 at 2:07 PM with the Chemical Company technician who was at the facility, revealed he came at least every 2 months or as needed to make sure the dishwashing machine was working correctly. The Chemical Company Technician was informed that the final rinse temperatures on 8/23/21 were never observed to be at or above 180 degrees. The Technician looked down at the machine and the temperature booster for the machine was off and he flipped the switch on, and the final rinse temperature rose to 180 degrees within a few minutes. On 8/25/21 at 2:30 PM an interview was conducted with the Chemical Company Technician by phone, and he stated that the dishes were sanitized in the final rinse and the temperature needed to be at least 180 degrees for sanitization to occur. Observation on 8/25/21 at 2:35 PM of the High temperature rinse aid's directions for use with High Temperature Dish Machines a minimum rinse temperature of 180 degrees F must be maintained during the rinse cycle for proper thermal sanitization. Interview with the DM and the Company Dietary Consultant on 8/25/21 at 2:49 PM revealed they were unaware that sanitization occurred in the high temperature rinse cycle. The Company Dietary Consultant stated that meals would need	F 812	per facility protocol. On 8/26/2021, the Administrator initiated an in-service with the Dietary Manager and dietary staff regarding Dishwasher temperature Booster being discontinued and implementing Any Temperature Chemical Combination for Low Temperature Machine. This in-service emphasized on the new installation of the any temperature chemicals and not requiring the booster for sanitizing. In-service will be completed by 9/29/2021, All newly hired Dietary Staff will be in-serviced during orientation regarding any Temperature Chemicals. On 8/23/2021, the Administrator initiated an in-service with the Dietary Manager and dietary staff regarding Labeling Food Items When Opened with emphasis on labeling all food items in the walk-in refrigerator with a use by date when opened. In-service will be completed by 9/29/2021 All newly hired Dietary Staff will be in-serviced during orientation regarding Labeling Food Items When Opened. The Administrator will complete an audit of the dishwasher Any Temperature Chemical Combination for Low Temperature Machine weekly x 4 weeks then monthly x 1 month utilizing the Any Temperature Chemical audit. This audit is to ensure that the Any Temperature Chemical Combination for Low Temperature Machine are being utilized in the dishwasher. The Dietary Manager will address all concerns identified during the audit to include re-washing dishes and notifying maintenance for any concerns	

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F 812	Continued From page 23 to be served on paper plates and plastic utensils and cups until the dishes could be rewashed and the machine was checked out again by maintenance. Interview with the Administrator on 8/26/21 at 10:49 AM revealed he had heard about the dishwasher from the DM and thought the water temperature booster had accidently been shut off. He further stated that the residents did eat off paper plates and plastic utensils and cups the night before. 2. Initial tour of the walk-in refrigerator on 8/23/21 at 10:27 AM revealed a plastic resealable bag with cheese slices in it and a Styrofoam container with cooked bacon and eggs undated. Another plastic resealable bag with ham and cheese slices and a bag of French toast was undated. Ham spread in a plastic container had an expired date of 7/27/21. Interview with the DM on 10/23/21 at 10:30 AM revealed all items in the walk-in refrigerator should have dates on them and they would have to be discarded along with the expired ham salad. 3. On 8/23/21 at 10:23 AM an initial observation of the dry storage room with the Dietary Manager (DM) revealed an opened bottle of vanilla extract without the lid and aluminum foil placed on top and was not dated. An open box of rice and an open box of instant mashed potatoes were not in airtight containers and were not dated. A case of water and a cardboard box of chips were on the floor. Interview with the DM on 8/23/21 at 10:26 AM revealed the opened items in the dry storage	F 812	and re-education of staff. The Administrator will review the Any Temperature Chemical Log weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will complete an audit of the walk-in refrigerator and dry storage weekly x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure all items in the walk-in refrigerator and dry storage are labeled with a use by date and no items stored on floor per facility protocol. The Administrator will address all concerns identified during the audit to include discarding items not labeled per facility protocol, items stored on floor and re-education of staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will present the findings of the Kitchen Audit Tool and the Any Temperature Chemical audit to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Kitchen Audit Tool and the Any Temperature Chemical audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 812	Continued From page 24 room should have been stored in airtight containers and dated. She further stated the items should not be stored on the floor. Interview with the Administrator on 8/26/21 at 2:15 PM revealed that he expected food that was expired to be thrown away and not in the walk-in refrigerator and opened foods should be dated. He further stated that he had heard about the temperatures in the dishwasher being too low and he indicated it should not have happened.	F 812		