STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted from 11/1/23 through 11/3/23. Event ID # LPR611. The following intakes were investigated NC00206561, NC00208257, NC00207681, NC00206004; NC00208207, NC00203248, NC009213, NC00209620, NC00208904. 5 of 28 allegations resulted in a deficiciency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to assess the ability of residents to self-administer medication for 2 of 2 sampled residents observed with medications at the bedside (Resident #11 and Resident #17). Findings included: 1. Resident #11 was admitted to the facility on 9/27/23 with diagnosis that included diabetes, chronic pancreatitis, chronic kidney disease, and adrenocortical insufficiency. An admission minimum data set assessment dated 10/3/23 revealed Resident #11 was cognitively intact with no behaviors or rejection of care.	F 554	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F- 554 Corrective action for resident involved Resident #11 no longer resides in the facility while #17 still resides in the facility. Corrective action for potentially impacted residents Evaluation for self-administration of medications of all alert and oriented	12/1/23

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

Electronically Signed | 11/30/2023

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F 554	Continued From page 1 Review of Resident #11's medical record revealed no documentation that Resident #11 was assessed for self-administration of medication. Review of Resident #11's care plan dated 10/4/23 revealed no documentation that Resident #11 was care planned for self-administration of medications. Review of physician's orders for Resident #11 revealed no order for self-administration of medications. Review of physician orders for Resident #11 revealed he received, Hydrocortisone give 5mg tablet by mouth for adrenocortical insufficiency, Creon DR 36,000units capsule by mouth for pancreatitis, and Sodium Bicarbonate 1 tablet by mouth daily for pancreatitis. An interview with Resident #11 and observation of his room were conducted on 11/1/23 at 1:28pm. Resident #11 was sitting in bed with his overbed table on his left side of the bed. On his overbed table, a medicine cup was observed to have one blue/gray capsule, one small round white pill and a white caplet. Resident #11 stated that Nurse #2 left the medication on the overbed table because when Nurse #2 came into the room. Resident #11 told Nurse #2 to give him a minute and Nurse #2 left the medication on the overbed table so Resident #11 could take the medication when he was ready. On 11/1/23 at 1:52pm, an interview and observation were conducted with Nurse #2. Nurse #2 indicated that she did go to Resident #11's room to give him his morning medication.	F 554	residents was conducted by the Director of Nursing and Unit Managers. The evaluation was completed on 11/28/2023. None of the residents desired to self-administer medications. Systemic Changes On 11/1/2023, education on the resident self-administration of medication policy was initiated by the Director of Nursing for all licensed nurses and medication aides. The education emphasized to never leave medications at beside unless following self-administration policy. Education will be completed by 11/30/2023. Any licensed nurses and medication aides that have not received the education will not be allowed to work until they are educated on self-administration of medication per policy. Newly hired nurses and medication aides will be educated on the policy by the Director of Nursing and Staff development Coordinator during new hire orientation. The Director of Nursing, Staff Development Coordinator and the Administrator are responsible for ensuring the education is conducted. Quality Assurance The Director of Nursing and/or designated nurse manager will monitor residents with the desire to self-administer medication and ensure self-administration assessment is completed per facility policy. This will occur weekly for 4 weeks and then monthly for 3 months using a residents self-administration monitoring tool. Reports will be presented to the weekly QA committee by the Administrator and/or Director of Nursing to ensure	

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F 554	Continued From page 2 Nurse #2 further indicated that she left the medication in a medicine cup, on his overbed table, as Resident #11 requested. Nurse #2 indicated that the one small round white pill was hydrocortisone 5mg, the one blue/gray capsule was Creon Dr 36,000 unit and the one white caplet was Sodium Bicarbonate. Nurse #2 stated Resident #11 did not have a self-administration order and she did not know it was wrong to leave the medication at bedside. An interview with the Director of Nursing (DON) was conducted on 11/3/23 at 1:23pm. DON indicated that residents should not have any medication at the bedside. Residents must be assessed for self -administration of medication and they should also have a physician order for self-administration of medication. If a resident did not have an assessment for self-administration of medications along with a physician's order, they should not have any medications at bedside. 2.Resident #17 was admitted to the facility on 8/19/2015 with diagnosis that included, chronic obstructive pulmonary disease, allergic rhinitis, and schizophrenia. A quarterly minimum data set assessment dated 8/4/23 revealed Resident #17 was cognitively intact with no behaviors or rejection of care. Review of Resident #17's medical record revealed no documentation that Resident #17 was assessed for self-administration of medication. Review of Resident #17's care plan dated 8/9/23 revealed no documentation that Resident #17 was care planned for self-administration of	F 554	corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the monthly QA meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager. Date of Compliance: 12/1/2023	

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F 554	Continued From page 3	F 554		

medications.

Review of physician's orders for Resident #17 revealed no order for self-administration of medications.

Review of physician orders for Resident #17 revealed Deep Sea Nasal (sodium chloride) aerosol spray 0.65% 1 spray each Nare twice a day for allergic rhinitis, Fluticasone propionate 50mcg/actuation 1 spray each Nare twice a day for allergic rhinitis.

A medication observation was conducted on 11/2/23 at 10:36am with Medication Aide (MA) #2. Resident #17 was in her room, sitting in her wheelchair, beside her bed with the overbed table in front of her. MA #2 was observed taking Deep Sea Nasal aerosol spray and Fluticasone propionate nasal spray from the medication cart and placing them on Resident #17's overbed table. MA#2 was observed leaving Resident #17's room without administering the two nasal spray medications. Resident #17 was observed taking the nasal sprays and spraying them into her nose without the presence of MA #2.

An interview with MA #2 was conducted on 11/2/23 at 10:50am. MA #2 indicated that she left Deep-Sea Nasal (sodium chloride) aerosol spray and Fluticasone propionate 50mcg/actuation spray in Resident #17 room because Resident #17 was able to self-administer the medication.

An interview with the Director of Nursing (DON) was conducted on 11/3/23 at 1:23pm. DON indicated that residents should not have any medication at the bedside. Residents must be assessed for self -administration of medication

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F 554	Continued From page 4 and they should also have a physician order for self-administration of medication. If a resident did not have an assessment for self-administration of medications along with a physician's order, they should not have any medications at bedside.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		12/1/23

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F 561	Continued From page 5 Based on record review, resident and staff interviews, the facility failed to honor resident requests for two showers per week for 2 of 2 sampled residents reviewed for self-determination (Resident #11 and Resident #8) Findings included: 1. Resident #11 was admitted to the facility on 9/27/23. An admission Minimum Data Set (MDS) assessment dated 10/3/23 revealed Resident #11 was cognitively intact, with no behaviors or rejection of care and required moderate assistance with showers. The facility's shower schedule revealed Resident #11 was scheduled for a shower on Monday and Thursday on day shift. Resident #11 medical record did not reveal any refusal of shower documented in the progress notes. The facility shower documentation from 9/27/23 through 11/1/23 revealed that Resident #11 had one shower documented on 10/30/23. The documentation revealed that Resident #11 was provided a partial bed bath instead of shower on the scheduled show dates of: 9/28/23,10/5/23,10/23/23/, and 10/26/23. The documentation revealed that Resident #11 was provided a complete bed bath instead of shower on the scheduled show dates of :10/2/23, 10/9/23,10/12/23, and 11/2/23. There was no documentation for the type of bath or shower provided to Resident #11 for the dates of	F 561	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F- 561 Corrective action for resident involved Resident #11 no longer resides in the facility. Resident #8 was offered a shower on 11/2/23 and she refused. On 11/7/23, resident agreed to and received a shower. Resident continues to be offered showers on her shower days or any other day she requests one. Resident's care plan has been updated. Corrective action for potentially impacted residents On 11/6/23, the Director of Nursing and Unit Managers reviewed all shower assignment sheets and no other residents were found to be affected by the deficiency. All residents will be offered showers on their designated days and/or any other day they request a shower. Residents who prefer bed baths will be given bed baths. All shower refusals are documented on the Skin Care Alert by the nurse Aide and signed by the charge nurse. On 11/7/23, the Director of Nursing, MDS Coordinator and Unit Managers reviewed all care plans and updated them as needed. Shower assignments are posted	

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F 561	Continued From page 6 10/16/23, 10/19/23 and 11/2/23. An interview with Resident #11 was conducted on 11/1/23 at 1:28pm. Resident #11 indicated that he had only received one shower since being admitted to the facility. Resident #11 indicated that he would ask for a shower on his scheduled days and staff would tell Resident #11 that they would be back, and they never come back to assist him with a shower. An interview was conducted on 11/1/23 at 1:37pm with Nurse Aide (NA) #1 who revealed Resident #11 had only received one shower since admission on 9/27/23. NA #1 stated that she did not know why resident #11 did not receive his showers on the scheduled days. She indicated that staff might not assist with showers if there was not enough time for staff to complete showers for residents, and thus they would complete a partial or complete bath. On 11/1/23 at 1:52pm, an interview was conducted with Nurse #2. Nurse #2 indicated that the nurse aides should give showers per the schedule, fill out a shower sheet that is signed by both the nurse aide and nurse, and also document the shower in the electronic record. Nurse #2 indicated that she had not received any shower sheets for Resident #11. Nurse #2 indicated that she could not confirm that Resident #11 had received a shower. An interview with the Director of Nursing (DON) was conducted on 11/3/23 at 1:23pm. The DON indicated residents should receive showers on their scheduled days. She further indicated that all nurse aides must follow the shower schedule, and if a resident refuses to take a shower, the	F 561	daily. Systemic Changes Education on resident rights regarding showers for all licensed nurses and nursing aides was conducted by the Director of Nursing and Unit Managers. Education was initiated on 11/8/23 and will be completed by 11/28/23. Any licensed nurses and nursing aides that have not received education will not be allowed to work until they are educated. Newly hired nurses and nursing aides will be educated on resident rights regarding showers by the Director of Nursing and Staff development Coordinator during new hire orientation. The Director of Nursing and Staff Development Coordinator are responsible for ensuring the education is conducted. Quality Assurance The Director of Nursing and/or designated nurse manager will monitor for residents with the desire to receive showers per shower schedule. This will occur weekly for 4 weeks and then monthly for 3 months using a residents shower sheet monitoring tool. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as needed. Compliance will be monitored, and ongoing audit program reviewed at the monthly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager.	

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F 561	Continued From page 7	F 561	Date of Compliance: 12/1/2023	

nurse aide should notify the nurse.

2. Resident #8 was admitted to the facility on 4/14/23.

An admission MDS assessment dated 4/21/23 revealed Resident #8 was cognitively intact, with no behaviors or rejection of care and required moderate assistance with showers.

The facility's shower schedule revealed Resident #8 was scheduled for a shower on Tuesday and Friday on evening shift.

Resident #8 medical record did not reveal any refusal of shower documented in the progress notes.

The facility shower documentation from 4/14/23 through 11/1/23 revealed that Resident #8 had one shower documented on 7/11/23. The documentation revealed that Resident #8 was provided a partial or completed or other type of bath instead of shower on the scheduled shower dates from 4/14/23 through 11/1/23 on Tuesdays and Friday except for 7/11/23.

An interview with Resident #8 was conducted on 11/1/23 at 1:39pm. Resident #8 indicated that she had one shower in the year she had been at the facility. Resident indicated that the nurse aide who provided her with a shower no longer worked at the facility. Resident #8 indicated she asks for a shower on her schedule shower days and staff do not assist her and some staff inform her they will come back to assist her, but they don't come back to resident's room.

An interview was conducted on 11/1/23 at 1:37pm

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F 561	Continued From page 8 with Nurse Aide (NA) #1 who revealed Resident #8 had only received one shower since admission on 4/14/23. NA #1 stated that she did not know why resident #8 did not receive his showers on the scheduled days. She indicated that staff might not assist with showers if there was not enough time for staff to complete showers for residents, and thus they would complete a partial or complete bath. On 11/1/23 at 1:52pm, an interview was conducted with Nurse #2. Nurse #2 indicated that the nurse aide should give showers per the schedule, fill out a shower sheet that is signed by both the nurse aide and nurse, and document the shower in the electronic record. Nurse #2 indicated that she had not received any shower sheets for Resident #8. Nurse #2 indicated that she could not confirm that Resident #8 had received a shower. An interview with the DON was conducted on 11/3/23 at 1:23pm. The DON indicated residents should receive showers on their scheduled days. She further indicated that all nurse aides must follow the shower schedule, and if a resident refuses to take a shower, the nurse aide should notify the nurse.	F 561		
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	F 580		12/1/23

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F 580	Continued From page 9	F 580		

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) 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

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F 580	Continued From page 10 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Behavioral Health Nurse Practitioner's interview, the facility failed to inform the resident's Responsible Party when there were changes in the resident's medications for 1 of 3 sampled residents reviewed for notification of changes (Resident #1). Findings included: Resident #1 was originally admitted to the facility on 7/20/23 with diagnosis of vascular dementia. The Behavioral Health Nurse Practitioner's progress note dated 8/2/23 was reviewed. Under recommendations, the note indicated that 25 mg Trazodone every 8 hours for 14 days was initiated for restlessness, and agitation. Resident #1 had doctor's order dated 8/2/23 for Trazodone 50 milligrams .5 tablet as needed every 8 hours for 14 days. This order was received by Nurse # 1. On 11/3/23 9:35 AM a telephone interview was conducted with the Behavioral Health Nurse Practitioner. He verified that he did not notify the RP of the medication change. Attempts to interview the RP were unsuccessful. On 11/3/23 at 3:01 PM, Nurse # 1 was interviewed. She did not recall working with Resident #1 on 8/2/23 and could not recall if she notified the responsible party of the medication	F 580	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F- 580 Corrective action for resident involved: Resident #1 no longer reside in the facility. Corrective action for potentially impacted residents: On 11/7/2023 the Director of Nursing and Unit Managers reviewed the last 30 days of residents' physician orders of residents on antidepressant medications to ensure Responsible Parties were notified of all changes in antidepressant medication. The review was completed on 11/10/23 and established that for any new orders and/or any changes, the Responsible Parties were notified when new orders and/or changes were effected. Systemic Changes: Education was initiated on 11/8/23 for all licensed nurses on the importance of	

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F 580	Continued From page 11 change. Review of the Physician's progress notes, and nurse's notes revealed no documentation that the resident's Responsible Party (RP) was informed of the changes in resident's medications. On 11/3/23 at 11:58 AM, the Director of Nursing (DON) was interviewed. She indicated that the nurse receiving the new order was responsible for notifying the RP when there was a change in resident's treatment/medication.	F 580	ensuring Responsible Parties are notified of all changes in resident medications and/or new orders. The education will be completed by 11/28/23. Any licensed nurses that have not received education will not be allowed to work until they are educated. Newly hired nurses and nursing aides will be educated on the importance of ensuring Responsible Parties are notified of all changes in resident medications and/or new orders by the Director of Nursing and Staff development Coordinator during new hire orientation. The Director of Nursing and Staff Development Coordinator are responsible for ensuring the education is conducted. Quality Assurance: The Director of Nursing or designated nurse manager will monitor for notification of Responsible Parties in the facility daily clinical meeting. This will occur weekly for 4 weeks and then monthly for 3 months using a residents antidepressant medication monitoring tool. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as needed. Compliance will be monitored, and ongoing auditing program reviewed at the monthly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager. Date of Compliance: 12/1/2023	

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	345225	A. BUILDING _____ B. WING _____	C 11/03/2023

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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 record review, observation, resident and staff interviews, the facility failed to ensure that residents did not possess smoking material for 2 of 2 sampled residents observed for accidents (Residents #11 and Resident #10). Findings included: The facility's smoking policy dated 2023 stated staff would keep smoking materials for residents until designated smoking times. Smoking times may be designated per facility protocol. All residents who were evaluated as safe smokers would be allowed to smoke at the time of their choosing without supervision. The residents evaluated as unsafe smokers would be supervised by designated facility staff at designated smoking times. On admission, residents who desired to smoke would have a smoking assessment completed. The care plan would be reviewed by the interdisciplinary team quarterly and as needed with any change in condition that would impact the resident's ability to safely smoke. 1. Resident #11 was admitted to the facility on 9/27/23.	F 689	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F-689 Corrective action for resident involved Resident #10 and resident # 11 no longer reside in the facility. Corrective action for potentially impacted residents On 11/3/23, smoking residents consented to room search and no smoking materials were found. On 11/3/23, the Director of Nursing and Unit Managers identified all residents that smoke and ensured they received an accurate smoking assessment by a licensed nurse and care plans were updated. This was completed on 11/8/23. By 11/10/2023, all smoking residents were reeducated by the DON and Unit	12/1/23

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F 689	Continued From page 13 An admission Minimum Data Set (MDS) assessment dated 10/3/23 revealed Resident #11 was cognitively intact with no behaviors or rejection of care. Resident #11's care plan dated 10/4/23 indicated that Resident #11 was care planned as a smoker with goal that resident would safely smoke. The Interventions included complete safe smoking evaluation on admission, quarterly and as needed, explain facility's smoking policy to resident and remind as needed. Resident #11's smoking assessment dated 11/2/23 indicated that resident was a smoker and was assessed to safely smoke in designated area. An interview with Resident #11 and observation of his room were conducted on 11/1/23 at 1:28pm. On top of his bedside table, one unlit cigarette was observed. Resident #11 indicated that he got the cigarette from the nurse and indicated he was about to go and smoke in the designated area. Resident #11 stated that he turns in his smoking material to the nurse after visiting the designated smoking area. On 11/1/23 at 1:52pm, an interview and observation were conducted with Nurse #2. Nurse #2 indicated that she did not give any resident cigarettes since the start of her shift at 7am. Nurse #2 also indicated that she did not have any cigarettes for any smoking resident kept on her medication cart. Nurse #2 indicated that sometimes cigarettes for residents who smoke were kept in the medication room. Nurse #2 indicated she had not given Resident #11	F 689	Managers on the facility Smoking Policy and the Facility Contraband Policy. Residents signed the smoking policy. Systemic Changes On 11/3/2023, education for all staff (including contractors) on the facility smoking policy. The policy ensures no residents are permitted to keep any smoking on them and that all smoking materials should be kept by the nurses in the medication carts or medication rooms and only given to residents when they are ready to go out to smoke. Smoking materials are returned to the nurse for safe keeping. The education will be completed by 11/30/2023. This training includes all current and contracted staff. Any staff that have not received education will not be allowed to work until they are educated. Newly hired staff will be educated on the facility smoking policy by the Director of Nursing, the Staff development Coordinator and/or the Administrator during new hire orientation. The Director of Nursing, the Staff Development Coordinator and the Administrator are responsible for ensuring the education is conducted. Facility management and administrative nurses will conduct weekly random checks to ensure residents are not keeping smoking materials on them. Quality Assurance and monitoring The Administrator or the designated manager will monitor all resident rooms weekly for 4 weeks and then monthly for 3 months using the smoking monitoring tool. Reports will be presented to the monthly	

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F 689	Continued From page 14 cigarettes. An interview and observation were conducted on 11/1/23 at 1:55pm with Unit Manager #1. Unit Manager #1 indicated that if cigarettes for residents were not in the medication cart, that they would be in the medication room. Unit Manager #1 then proceeded to the Medication Room to show the cigarettes, but no resident cigarettes were in the medication room. Unit Manager #1 indicated that she did not give Resident #11 cigarettes since starting her shift that morning. At 11:02pm on 11/2/23, an observation was made in the designated smoking area. Resident #11 was observed entering the designated smoking area with a cigarette in his hand. An interview and observation was conducted at 11:12pm on 11/2/23 with Resident #11 in the designated smoking area. Resident #11 was observed to have an unlit cigarette. Resident #11 indicated that he had received the cigarette from Nurse #3. Resident #11 was observed lighting his cigarette while in the designated smoking area. Resident #11 stated that he turns in his smoking material to the nurse after visiting the designated smoking area. While at the nursing station from 11:58am to 12:08pm, a continuous observation was made on 11/2/23 of Resident #11 leaving his room and heading towards designated smoking area with an unlit cigarette in his hand. Resident #11 was then followed into the designated smoking area at 12:09pm.	F 689	QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as needed. Compliance will be monitored and ongoing auditing program, reviewed at the monthly QA meeting. The monthly QA meeting is attended by the Administrator, DON, Director of Social Services, MDS Coordinator, Medical Records Director, and the Dietary Manager. Date of Compliance: 12/1/2023	

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F 689	Continued From page 15	F 689		

An observation and interview was conducted with Resident #11 at 12:10pm on 11/2/23 while in the designated smoking area. Resident #11 indicated that he had just received a cigarette from Nurse #3 prior to getting into the designated smoking area. Resident #11 was observed lighting the cigarette while in the designated smoking area. Resident #11 stated that he turns in his smoking material to the nurse after visiting the designated smoking area.

Observation and interview was conducted with Nurse #3 at 12:26pm on 11/2/23. Nurse #3 indicated that Resident #11 was assigned to her. Nurse #3 indicated that she kept the cigarettes and lighters for residents who smoke in the medication cart drawer. Nurse #3 indicated that she did not have any cigarettes or lighter for Resident #11 in the medication cart and she did not give Resident #11 any cigarettes since the start of her shift that morning at 7am.

An interview was conducted at 12:29pm on 11/2/23 with the Director of Nursing (DON) and she was unaware that Resident #11 had any cigarettes on his person, and she would immediately follow up.

An interview was conducted at 1:22pm on 11/2/23 with the DON, and she indicated that Resident #11 did have cigarettes in his room, inside his bedside table, that were not turned in to the facility to be stored.

An interview with DON was conducted on 11/3/23 at 1:23pm. The DON indicated residents smoking materials should be locked up and kept by nursing staff. She further indicated Resident #11 was to obtain smoking materials from the nurse

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F 689	Continued From page 16	F 689		

and return the smoking materials after going to the facility's designated smoking area.

2.Resident #10 was admitted to the facility on 8/21/23.

An admission MDS assessment dated 8/28/23 revealed Resident #10 was cognitively intact with no behaviors or rejection of care.

Resident #10's care plan dated 10/4/23 indicated that Resident #10 was care planned as a smoker with goal that resident wound safely smoke. The Interventions included complete safe smoking evaluation on admission, quarterly and as needed, explain facility's smoking policy to resident and remind as needed.

Resident #10's smoking assessment dated 8/21/23 indicated she was a smoker and was assessed to safely smoke in designated area.

At 11:02pm on 11/2/23, an observation was made in the designated smoking area. Resident #10 was observed entering the designated smoking area with an unlit cigarette in her hand.

An interview and observation was conducted at 11:10pm on 11/2/23 with Resident #10. Resident #10 was observed to have an unlit cigarette. Resident #10 indicated that she had received the cigarette from Nurse #3. Resident #10 stated that she turns in her smoking material to the nurse after visiting the designated smoking area.

Observation and interview was conducted with Nurse #3 at 12:26pm on 11/2/23. Nurse #3 indicated Resident #10 was assigned to her and she kept the cigarettes and lighters for residents

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F 689	Continued From page 17 who smoke in the medication cart drawer. She did not have any cigarettes or lighter for Resident #10 in the medication cart and did not give Resident #10 any cigarettes since the start of her shift that morning at 7am. An interview was conducted at 12:29pm on 11/2/23 with the DON and she was unaware that Resident #10 had any cigarettes on his person, and she would immediately follow up. An interview was conducted at 1:22pm on 11/2/23 with the DON, and she indicated that Resident #10 did have cigarettes in her room, inside her bedside table, that were not turned in to the facility to be stored. An interview with DON was conducted on 11/3/23 at 1:23pm. The DON indicated residents smoking materials should be locked up and kept by nursing staff. She further indicated Resident #10 was to obtain smoking materials from the nurse and return the smoking materials after going to the facility's designated smoking area.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804		12/1/23

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F 804	Continued From page 18 Based on test tray observation, record reviews and interviews with residents and staff the facility failed to serve food that was palatable and at temperatures acceptable to 2 of 2 residents review for food palatability. (Resident #2 and #18) This practice had the potential to affect other residents. Findings included: a. Resident #2 was admitted to the facility on 4/28/21 and re-admitted on 09/21/23. A review of the Minimum Data Set (MDS) dated 09/16/23 revealed Resident #42 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #2 on 11/01/23 at 12:30 pm she indicated she had concerns with all her meals being cold, Resident #2 alleged the food was unappealing because the food was often under or over cooked. She talked about the grits not being hot and clumpy and not seasoned. She indicated she had reported this information to the Administrator in September and the food was still not good. Resident #2 also indicated she had called her family many times for food and ordered takeout. During this interview Resident #2 was observed eating her lunch consisting of ham and mashed sweet potatoes and she reported the food was cold. A second interview was conducted with Resident #2 on 11/02/23 at 3:05 pm, Resident #2 indicated that lunch was late. Resident #2 indicated that the meatballs were cold, mashed potatoes were runny and cold too, green beans were cold and lacked seasoning. This observation was observed	F 804	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F-804 Corrective action for resident involved. Resident #2 and resident #18 are still residing in the facility. On 11/2/23 the District Dietary Manager and the Dietary Manager completed food palatability and temperature preferences for resident #2 and Resident # 18. Corrective action for potentially impacted residents. On 11/3/2023 the District Dietary Manager and the Dietary Manager completed Meal Test trays on three meals during breakfast, lunch, and dinner and established the meals were palatable and the required temperature. On 11/8/2023, the Administrator completed meal test trays for breakfast, lunch and dinner and established the meals were palatable and at the required temperature. All meal test trays were found to be palatable and at appropriate temperatures. On11/6/2023, the Maintenance Director evaluated the facility plate warmer system to ensure it was operating per manufacturers specifications and it was established the plate warmer is in working	

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F 804	Continued From page 19 during this interview. b. Resident #18 was admitted to the facility on 05/26/23. A review of the Minimum Data Set (MDS) dated 09/02/23 revealed Resident #18 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #18 on 11/01/23 at 12:45 pm she indicated she had concerns with her meals being cold. Resident #2 indicated that her daughter had got lunch for her today and she did not eat the food during lunch. Resident #18 indicated that sometimes she ate the food cold, because no one would heat the food up. Resident #18 indicated that she has complained before, and no one did anything about the meals being cold. A second interview conducted with Resident #18, on 11/02/23 at 3:15 pm she indicated that the food was cold. She indicated also that her meatballs were cold and dry. Mashed potatoes were runny and green beans were cold too. During this interview Resident #18 meal tray was observed. An observation of the meal tray line service in the kitchen was conducted on 11/02/23 at 2:00pm. The food items were placed on heated plates from a plate warmer. The plated meals were covered with insulated, dome shaped lids with bottoms. A test meal tray of the regular textured foods was included in the meal delivery cart. On 11/02/23 at 2:18pm, after the residents of the 100 halls were served, the Dietary Manager and	F 804	as required. Systemic Changes Dietary staff and the Dietary Manager were re-educated on preparing palatable food and serving the food at the required temperatures by the District Dietary Manager on 11/2/2023. This education will be completed by 11/15/2023for all dietary staff. Staff that have not received education will not be allowed to work until education is provided by the Dietary Manager and/or the District Manager. Quality Assurance and monitoring. It is the responsibility of the Dietary Manager and/or the cook to ensure food is served at the right temperatures and is palatable. The Dietary Manager and/or the cook will be responsible for testing meal trays 3 times a week for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately addressed with 1:1 re-education completed immediately. The reviews of the Test trays will be forwarded to the Administrator and/or the Director of Nursing for review. The results of the Test Tray audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Reports will be presented to the monthly QA committee by the Administrator and/or the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing audit program reviewed at the monthly QA meeting. The	

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F 804	Continued From page 20 the Surveyor observed the test meal tray for palatability. The meatballs, mashed potatoes and green beans were warm, not hot. The DM participated in the testing of the meal tray and acknowledged these findings. During an interview on 11/03/23 at 1:30pm., the Dietary Manager revealed she been working at the facility for two years and did not frequently receive complaints from residents concerning the quality of the food. During an interview with the Dietary Manager and District Manager on 11/03/23 at 1:35pm indicated that their expectation was that all residents would receive good hot food and food on time daily. During an interview with the Director of Nursing at 11/03/23 at 2:30pm she indicated that her expectations was the dietary staff to provide palatable food and temperature according to the regulations for all residents.	F 804	monthly QA meeting is attended by the Administrator, DON, Social Services Director, MDS Coordinator, Medical Records Director, and the Dietary Manager. Date of Compliance: 12/1/2023	