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	345285	A. BUILDING _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE DRIVE HENDERSONVILLE, NC 28739

(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 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (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. (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. (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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to provide 2 of 7 sampled residents the opportunity to demonstrate the ability to smoke independently. (Residents #33 and #59). The Findings included: The facility's smoking policy referenced from and dated 2001 MED-PASS, Inc. (Revised April 2012) included the following procedures: 1. Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences; for example, in making room assignments. 6. The staff shall consult with the Attending	F 242	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #33 was assessed by licensed nurse on April 5, 2017, utilizing the facility smoking assessment tool. The resident was also visually assessed by licensed nurse for demonstration of ability to smoke safely. Following the assessment the findings, which assessed the resident to be supervised, were reviewed by the interdisciplinary care plan team and the recommendations regarding smoking results were discussed. Nurse Practitioner was consulted by Director of Nursing regarding assessment results and was in agreement on April 6, 2017. Resident care plan was updated to reflect	4/13/17

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

Electronically Signed | 04/10/2017

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F 242	Continued From page 1 Physician and the Director of Nursing Services to determine any restrictions on a resident's smoking privileges. 7. Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 8. Residents with smoking privileges may only smoke during supervised smoking breaks while at the facility. 12. The staff will review the status of a resident's smoking privileges quarterly, and consult as needed with the Director of Nursing Services and the Attending Physician". An undated paper with a typed list of designated smoking times and designated smoking area revealed as follows: 6-6:15 am 9-9:15 am 11-11:15 am 2-2:15 pm 4:30-4:45 pm 7:30-7:45 pm 9-9:15 pm Breezeway A Smoking Contract (SC) signed by Resident #33 on 09/16/13 agreeing to abide by the facility's smoking restrictions and hours was noted in Resident #33's medical record. Review of Resident #33's annual Minimum Data	F 242	assessment results and resident was notified of results by Director of Nursing and was in agreement with the assessment on April 6, 2017. Resident #59 was assessed by licensed nurse on April 5, 2017, utilizing the facility smoking assessment tool. The resident was also visually assessed by licensed nurse for demonstration of ability to smoke safely. Following the assessment the findings, which assessed the resident to be supervised, were reviewed by the interdisciplinary care plan team and the recommendations regarding smoking results were discussed. Nurse Practitioner was consulted by Director of Nursing regarding assessment results and was in agreement n April 6, 2017. Resident care plan was updated to reflect assessment results and resident was notified of results by Director of Nursing and was in agreement with the assessment on April 6, 2017. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility that smoke will be assessed for their smoking abilities utilizing the smoking assessment and visual observation. Their plan of care will be updated to reflect the assessment by April 13, 2017. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur?	

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F 242	Continued From page 2 Set (MDS) dated 01/31/17 revealed he was readmitted to the facility on 01/03/15 and had the current diagnoses that included cerebrovascular accident, hemiparesis and anxiety. The MDS also revealed Resident #33 to be cognitively intact for daily decision making, required limited assistance with dressing, fed himself and currently used tobacco. Review of Resident #33's Smoking care plan dated 01/31/17 noted he started to smoke and was at risk for injury. The goal was for Resident #33 to not sustain injury from smoking using interventions such as providing the policy and procedure, see with smoking apron when smoking, provide supervision when smoking at scheduled times and keep smoking materials in cart close to nursing station. Review of a Smoking Risk Assessment (SRA) dated 01/31/17 revealed Resident #33 was assessed by the Social Worker (SW) as having paralysis, dementia and receiving antianxiety medications. The recommendation of the assessment was for Resident #33 to have supervised smoking. Observations of Resident #33 on 03/13/17 at 2:05 PM revealed he along with other residents in the breezeway smoking while being supervised by two hospitality aides. Resident #33 wore a smoking protector and held the cigarette with his left hand to smoke. After he finished with the cigarette, he handed it to a hospitality aide then took another cigarette from the aide and she lit it for him. When Resident #33 finished with his second cigarette, he handed it to the hospitality aide then wheeled himself into the building.	F 242	a. All current residents that smoke will be assessed by a licensed nurse or Social Services Director utilizing the smoking assessment tool. Also, the residents will be visually assessed by licensed nurse or Social Services Director for demonstration of ability to smoke safely. The findings of the assessments will be discussed by the interdisciplinary care plan team and referred to the Physician or Nurse Practitioner for review and approval. Resident care plan will be updated to reflect the recommendations from the smoking assessment and will be discussed with the resident by the Director of Nursing or Assistant Director of Nursing by April 13, 2017. b. Any new admission to the facility will be assessed by a licensed nurse or Social Services Director utilizing the smoking assessment tool. Also, the resident will be visually assessed by licensed nurse or Social Services Director for demonstration of ability to smoke safely. The findings of the assessments will be discussed by the interdisciplinary care plan team and referred to the Physician or Nurse Practitioner for review and approval. Resident care plan will be implemented to reflect the recommendations from the smoking assessments and will be discussed with the resident by the Social Services Director, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator. c. All smoking residents will be reviewed	

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F 242	Continued From page 3 On 03/14/17 at 9:10 AM Resident #33 along with other residents were observed in the breezeway smoking while being supervised by two hospitality aides. Resident #33 wore a smoking protector and held the cigarette with his left hand to smoke. After he finished with the cigarette, he handed it to a hospitality aide and then took another cigarette from the aide and she lit it for him. After he finished with his cigarette, he handed it to the aide then wheeled himself into the building. On 03/15/17 at 9:05 AM Resident #33 and other residents were observed smoking in the breezeway while being supervised by two hospitality aides. Resident #33 wore a smoking protector and held the cigarette with his left hand to smoke. After he finished with the cigarette, he handed it to a hospitality aide and then took another cigarette from the aide and she lit it for him. When he was finished with the cigarette, he handed it to the aide and wheeled himself into the building. Interview with Nurse #1 on 03/13/17 at 4:00 PM revealed the residents who desired to smoke were informed on admission that the facility required smokers to be supervised and they could not keep smoking materials in their rooms. Nurse #1 also stated the Social Worker (SW) completed an initial smoking assessment on admission and quarterly on the residents who desired to smoke. Interview with Resident #33 on 03/15/17 at 8:46 AM stated he would like to be able to smoke when he wanted but he had never been given the choice nor had he ever been asked to demonstrate his ability to smoke safely.	F 242	quarterly or as needed per the MDS assessment schedule. d. 100% of licensed staff and interdisciplinary care plan team will be in-serviced on smoking assessment and visual observation of smoking by April 13, 2017, by the Staff Development Coordinator, Director of Nursing or Assistant Director of Nursing. e. 100% of staff will be in-serviced on smoking policy by April 13, 2017, by the Staff Development Coordinator, Director of Nursing or Assistant Director of Nursing f. An audit of smoking residents will be completed monthly, for residents that trigger from the MDS assessment schedule and new admissions, by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinator or Licensed nurse to ensure smoking assessment is complete, Interdisciplinary team note is present, Nurse practitioner note is present, resident review of assessment is present and Care Plan is current per the assessment. This will be completed monthly x 12 months. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will report results of the smoking audit review for residents	

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F 242	Continued From page 4 Interview with the SW on 03/16/17 at 3:35 PM revealed that the Smoking Policy was explained to the residents who desired to smoke on admission and were asked to sign a SC. The SW explained the facility's Smoking Policy allowed the residents to smoke under supervision at the seven set smoking times and they could smoke as many cigarettes as they wanted for fifteen minutes. She stated it was her responsibility to complete a SRA which was a questionnaire that was completed quarterly and with significant changes in the resident. The SW further stated that the questionnaire did not include having the resident return demonstration of lighting, smoking and extinguishing a cigarette. On 03/16/17 at 6:30 PM an interview with both the Administrator and the Director of Nursing (DON) revealed the Smoking Policy had been in place for at least nine years and had always been a questionnaire. The Administrator stated they do not have the residents return demonstration of safe smoking because the facility only allowed supervised smoking. The Administrator also stated that no residents have asked to be able to smoke independently. The DON added she thought they needed to look at the smoking assessment. 2. Resident #59 was admitted to the facility 05/15/15 with diagnoses of dementia, heart failure, and asthma. A review of the quarterly Minimum Data Set (MDS) dated 01/23/17 indicated Resident #59 was cognitively intact with no disorganized thinking or inattention behaviors. A review of the annual MDS dated 10/28/16 indicated Resident #59 was cognitively intact and used tobacco products.	F 242	assessed for smoking in the month per the MDS assessment schedule and all new admissions. The results will be reported to the Quality Assurance Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a Certified Nursing Assistant meeting monthly x 12 months for follow up and/or recommendations.	

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F 242	Continued From page 5	F 242		

The care plan review date was 01/23/17 and indicated Resident #59 was a smoker and at risk for injury. Interventions included: provide with a smoking policy and procedures and ensure smoking materials are available. Ensure a smoking apron is available and offer supervision during scheduled smoke breaks.

An observation of supervised smoking with Resident #59 was done on 03/14/17 at 9:14 AM and revealed he was wearing a smoker's apron. A cigarette was provided by the Hospitality Aide (HA) #1. The HA #1 lit his cigarette. Resident #59 safely smoked the cigarette. When finished the cigarette was given to the HA #1 who extinguished in a fire proof container. There were no concerns noted during the observation of Resident #59 safely smoking.

During an interview with HA #1 on 03/14/17 at 9:14 AM she revealed a smoking cart was used to store the residents' smoking materials. The HA's used their own lighters. A list was provided to the HA's that explained smoking break times and how many cigarettes the resident could have during each smoke break. There was no unsupervised smokers list provided.

During an interview with Resident #59 on 03/16/17 at 10:29 AM he confirmed he had always been supervised when smoking. Resident #59 stated he would like to smoke unsupervised but had never been asked to demonstrate safe smoking. He confirmed an oxygen concentrator was used when in his room and he did not use an oxygen tank attached to the wheelchair. Resident #59 revealed if he was late for a smoking break then he must wait until the next break and smoking was one of the few things he had left as

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F 242	Continued From page 6 a freedom of choice. Interview with the SW on 03/16/17 at 3:35 PM revealed that the Smoking Policy (SP) was explained to the residents who desired to smoke on admission and were asked to sign a SC. The SW explained the facility's Smoking Policy allowed the residents to smoke under supervision at the seven set smoking times and they could smoke as many cigarettes as they wanted for fifteen minutes. She stated it was her responsibility to complete a SRA which was a questionnaire that was completed quarterly and with significant changes in the resident. The SW further stated that the questionnaire did not include having the resident return demonstration of lighting, smoking and extinguishing a cigarette. On 03/16/17 at 6:30 PM an interview with both the Administrator and the Director of Nursing (DON) revealed the Smoking Policy had been in place for at least nine years and had always been a questionnaire. The Administrator stated they do not have the residents return demonstration of safe smoking because the facility only allowed supervised smoking. The Administrator also stated that no residents have asked to be able to smoke independently. The DON added she thought they needed to look at the smoking assessment.	F 242		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by:	F 253		5/16/17

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F 253	Continued From page 7 Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate on 8 of 62 room entry doors on 2 of 2 wings (Resident room #207, #211, #217, #223, #227, #228, #231, and #308. The facility also failed to repair broken and splintered laminate on 2 of 29 shared bathroom doors on 1 of 2 wings (Resident room #218 and #223), replace overbed tables with missing or peeling vinyl in 3 rooms on 2 of 2 wings (Resident room #217, #221, and #306), replace cracked and discolored caulking at the base of toilets, keep bathroom doors free of scratches, paint scratched bathroom walls, repair dry wall, and remove stains from a bathroom floor for 12 of 29 shared bathrooms on 2 of 2 wings. In addition, the facility also failed to label and properly store personal hygiene products, personal care equipment, and plungers on 2 of 2 wings. The findings included: An interview was conducted with the Maintenance Director on 03/16/17 at 4:19 PM. The Maintenance Director stated he had worked at the facility for 5 years and had one assistant who worked 30 hours a week. The interview revealed rooms were audited monthly for needed repairs and painting. Quarterly audits were conducted for bedside tables, overbed tables, sinks, and caulking. The Maintenance Director noted his assistant was painting and caulking on the 200 hall this week. In addition, the rooms on the 300 hall had a complete audit in January of 2017 and the list of repairs and painting were completed in February of 2017. The Maintenance Director further stated there was a clip board on both sides of the facility with work orders for staff to	F 253	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Overbed tables in rooms #217, #221 and #306a were replaced March 17, 2017. The wall in shared bathroom for #301 and #303 was repaired and the caulking around the toilet was replaced on April 4, 2017. The caulking around the toilet for shared bathroom for rooms #302 and #304 was replaced on April 4, 2017. Shared bathroom for rooms #309 and #311 paint scratched off was repaired on April 4, 2017. Shared bathroom for rooms #309 and #311 caulking was replaced on April 4, 2017. The baseboard in room #309 was repaired on April 4, 2017. Shared bathroom #313 and #315 caulking was replaced on April 4, 2017. Shared bathroom #210 and #212 the scratch on the wall will be repaired by April 13, 2017. Shared bathroom #218 and #220 the scratch on the wall will be repaired by April 13, 2017. Shared bathroom #221 and #223 the scratch on the wall will be repaired by April 13, 2017. Shared bathroom #226 and #228 the scratch on the wall will be repaired by April 13, 2017. Shared bathroom #229 and #231 the scratch on the wall will be repaired by April 13, 2017.	

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F 253	Continued From page 8 communicate needed repairs. 1. a. Observations of the shared bathroom for rooms 301 and 303 made on 03/13/17 at 4:16 PM, 03/14/17 at 12:17 PM, 03/15/17 at 3:20 PM, and 03/16/17 at 10:20 AM revealed the wall in front of the toilet had the paint scratched off almost the entire width of the wall approximately 12 inches from the floor and the caulking at the base of the toilet was cracked and discolored. An interview was conducted with the Maintenance Director on 03/16/17 at 5:39 PM after observations of the shared bathroom for rooms 301 and 303. The Maintenance Director stated the wall in the bathroom needed to be added to the touch up list and the caulking at the base of the toilet needed to be replaced. b. Observations of the shared bathroom for rooms 302 and 304 made on 03/13/17 at 2:50 PM, 03/14/17 at 11:23 PM, and 03/15/17 at 3:54 PM revealed the caulking at the base of the toilet was cracked and discolored. An interview was conducted with the Maintenance Director on 03/16/17 at 5:37 PM after observations of shared bathroom for rooms 302 and 304. The Maintenance Director agreed the caulking needed to be replaced at the base of the toilet and thought he may need take up the toilet to see if there was a leak. c. Observations of the overbed table in room 306 bed A on 03/13/17 at 3:10 PM, 03/14/17 at 12:18 PM, 03/15/17 at 3:50 PM, and 03/16/17 at 10:24 AM revealed approximately 7 inches of the vinyl strip from the edge of the overbed table was missing leaving exposed particle board which had	F 253	Shared bathroom #314 and #316 drywall to the right of the sink was repaired on April 5, 2017. Shared bathroom #323 and #325 drywall above the soap dispenser was repaired April 6, 2017. The resident room doors for #207, #211, #217, #223, #227, #231, #308 and shared bathroom doors #218 and #223 will be patched to reduce the potential for resident harm by April 13, 2017. All resident personal items will be labeled and bagged (if resident choice) by April 13, 2017. Plunger in shared bathroom #310 and #312 was bagged on March 16, 2017. Plunger in shared bathroom #210 and #212 was bagged on March 16, 2017. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of overbed tables was completed by the Maintenance Director on April 4, 2017. Any overbed table in need of repair was replaced. An audit will be completed for unlabeled personal care items by the Director of Nursing, Assistant Director of Nursing, Ancillary Clerk or hospitality aide by April 13, 2017. Items will be bagged and labeled properly. The resident room doors for #207, #211,	

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F 253	Continued From page 9 a rough surface. An interview was conducted with the Maintenance Director on 03/16/17 at 5:31 PM after observations of the overbed table in room 306 A. The Maintenance Director stated the overbed table needed to be replaced because the rough edges could cause a skin tear or a cut. The Maintenance Director noted he just did a facility wide count of wardrobes, night stands, and overbed tables but did not recall if he noticed this particular overbed table. d. Observations of the entry door for room 308 made on 03/13/17 at 4:39 PM, 03/14/17 at 12:23 PM, and 03/15/17 at 3:47 PM revealed broken and splintered laminate and wood on the lower half of the hinge side of the door. An interview conducted with the Maintenance Director on 03/16/17 at 5:30 PM after observations of the entry door for room 308. The Maintenance Director agreed the splintered wood could cause injury to the residents and they would need to fill in the splintered edges of the door with wood putty and sand until a decision was made about replacing the doors or a better solution was found. The Maintenance Director stated during an earlier interview at 4:41 PM that 90% of the doors had splintered wood from being hit by wheelchairs and lifts. e. Observations of the shared bathroom for rooms 309 and 311 made on 03/13/17 at 3:22 PM, 03/14/17 at 11:30 AM, and 03/15/17 at 3:33 PM revealed the wall in front of the toilet had the paint scratched off almost the entire width of the wall approximately 12 inches from the floor and the caulking and floor at the base of the toilet was	F 253	#217, #223, #227, #231, #308 and shared bathroom doors #218 and #223 will be patched to reduce the potential for resident harm by April 13, 2017. An audit of 100% of all doors was completed on April 7, 2017, by the Maintenance Director. It was noted that 126 doors needed to be replaced. Of that number, 42 doors were noted to have the most significant need for repair. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur? In-servicing of properly labeling personal care items will be conducted with 100% of the staff by April 13, 2017, by the Staff Development Coordinator, Director of Nursing, or Assistant Director of Nursing. In-servicing for proper storage and bagging of plungers will be conducted with 100% of the staff by April 13, 2017, by the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing or Maintenance Director. In-servicing of completion of a work order will be conducted with 100% of the staff by April 13, 2017, by the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing, or Maintenance Director. Maintenance Director and Assistant Maintenance Director will be in-serviced on completion of work orders and filing of	

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F 253	Continued From page 10 stained a rust color. There was also a piece of baseboard approximately 8 inches long missing to the left of the bathroom door in room 309. An interview was conducted with the Maintenance Director after observations in room 309 and the shared bathroom for room 309 and 311. The Maintenance Director stated the bathroom wall needed to be added to the touch up list and he would have the floor tech work on the bathroom floor. The Maintenance Director explained a floor tech left in October 2016 and the most recent floor tech had started two weeks ago. In addition, the missing baseboard in room 309 needed to be replaced. f. Observations of the shared bathroom for rooms 313 and 315 made on 03/14/17 at 9:07 AM, 03/15/17 at 3:45 PM, and 03/16/17 at 10:28 AM revealed the caulking at the base of the toilet was cracked and discolored and a 2 inch piece of the caulking was pulled away from the toilet. An interview was conducted the the Maintenance Director on 03/16/17 at 5:22 PM after observations of the shared bathroom for rooms 313 and 315. The Maintenance Director stated the spacing of the caulking concerned him because it could cause odor and tile rot. The Maintenance Director thought this bathroom may have been on the room audit list with repairs completed by February 2017 but was not sure. During an interview on 03/16/17 at 5:52 PM the Administrator stated the facility was trying to decide whether to use coverings or replace the doors. She agreed the splintered doors were a potential for injury and there needed to be a temporary solution until a decision was made.	F 253	completed work orders and facility physical plant repairs by April 13, 2017, by the Administrator. A personal item audit which includes labeling or bagging personal items will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Central Supply Clerk, Environmental Services Supervisor or Administrator. On April 11, 2017, 42 doors will be ordered by the Maintenance Director. The anticipated date for installation is May 16, 2017. The remaining doors will be replaced by replacing 30 doors per quarter until all doors in need of repair are replaced. A physical plan audit which includes, but is not limited to, walls, baseboards, toilets, doors, trim and sinks will be completed weekly x 2 months, bi-weekly x 2 months and monthly x 6 months. The audit will be completed by the Administrator, Director of Nursing, or Environmental Services Supervisor. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. A personal item audit which includes labeling or bagging personal items will be conducted weekly x 4 weeks, bi-weekly x 2 months and monthly x 3 months. The audit will be completed by the Director of Nursing, Assistant Director of Nursing or	

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F 253	Continued From page 11 2. a. Observations of the shared sink in room 301 made on 03/15/17 at 3:20 PM, 03/16/17 at 10:20 AM, and 03/16/17 at 3:09 PM during observations with the Director of Nursing (DON) revealed an unlabeled comb on the back of the sink behind the faucet. b. Observations of the shared sink in room 302 on 03/13/17 at 2:49 PM and 03/14/17 at 11:24 AM revealed an unlabeled brush, comb, and bottle of periwash on the back of the sink. Observations on 03/15/17 at 3:54 PM and during observations with the DON on 03/16/17 at 3:10 PM revealed an unlabeled brush and bottle of periwash on the back of the sink. c. Observations of the shared sink in room 306 made on 03/13/17 at 3:10 PM revealed 2 uncovered and unlabeled toothbrushes and an unlabeled tube of toothpaste on the back of the sink. Subsequent observations on 03/14/17 at 12:19 PM, 03/15/17 at 3:51 PM, and 03/16/17 at 3:10 PM during observations with the DON revealed 2 uncovered and unlabeled toothbrushes and a tube of toothpaste, a bottle of periwash and a bottle of shampoo/body wash that were not labeled. d. Observations of the shared sink in room 308 made on 03/13/17 at 4:37 PM and 03/14/17 at 12:23 PM revealed an unlabeled brush, comb, bottle of lotion, and periwash on the back of the sink. Subsequent observations on 03/15/17 at 3:49 PM	F 253	Staff Development Coordinator, Central Supply Clerk, Environmental Services Supervisor or Administrator. The results of the audit findings will be presented by the Director of Nursing to the monthly Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (infection Control Representative), Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a certified Nursing Assistant meeting monthly for 6 months for further follow-up and/or recommendations. A physical plant audit which includes, but is not limited to, walls, baseboards, toilets, doors, trim and sinks will be completed weekly x 2 months, bi-weekly x 2 months and monthly x 6 months. The audit will be completed by the Administrator, Environmental Services Supervisor or Director of Nursing. The results of the audit findings will be presented by the Environmental Services Supervisor or Administrator to the Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff	

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and during observations with the DON on 03/16/17 at 3:13 PM revealed an unlabeled brush and comb on the back of the sink.

e. Observations of the shared bathroom for rooms 309 and 311 made on 03/13/17 at 3:24 PM, 03/14/17 at 11:30 AM, 03/15/17 at 3:33 PM, and during observations with the DON on 03/16/17 at 3:17 PM revealed an unlabeled graduated cylinder on the back of the toilet and an unlabeled urine collection hat and a plunger resting on top of a bag both on the floor near the toilet.

f. Observations of the shared bathroom for rooms 310 and 312 made on 03/13/17 at 2:43 PM, 03/14/17 at 12:26 PM, 03/15/17 at 3:37 PM, and during observations with the DON on 03/16/17 at 3:19 PM revealed a plunger on the floor next to the toilet.

During an interview on 03/16/17 at 2:27 PM Nurse #3 stated personal hygiene and personal care products were kept in zip top bag labeled with the resident's name. Nurse #3 indicated personal care equipment should be labeled and bagged.

An interview with Nurse Aide (NA) #3 on 03/16/17 at 2:31 PM revealed personal hygiene and personal care products should be labeled and stored in a zip top bag. NA #3 stated graduated cylinders should be labeled and placed on the back of the toilet. The interview further revealed the NAs did not leave personal care equipment on the bathroom floors.

An interview was conducted with the DON during the observations of residents' rooms and

Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse, and a certified nursing assistant meeting monthly for 10 months for further follow-up and/or recommendations.

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bathrooms which started on 03/16/17 at 3:01 PM. The DON stated personal hygiene products should be labeled if they were stored on the back of the sink but she preferred personal items to be labeled with the resident's name and stored in a zip top bag. The DON indicated toothbrushes should never be stored uncovered. The DON further stated urine collection hats should be discarded once the specimen was collected and graduated cylinders should be labeled and stored in a bag on the back of the toilet. In addition, plungers could be stored in bathroom but should have a bag tied around them.

3. a. Observations of the shared bathroom in rooms 210 and 212 on 03/15/17 at 10:42 AM revealed the inside of both bathroom doors and the wall in front of the toilet were scratched. The subsequent observations were on 03/16/17 at 8:11 AM and 4:47 PM in which the conditions remained unchanged.

b. Observations of the bedroom in room 217 on 03/13/17 at 4:26 PM revealed the vinyl on the overbed table edge was peeled back which left sharp edges. The subsequent observations were on 03/14/17 at 8:14 AM and 03/16/17 at 4:55 PM in which the conditions remained unchanged.

c. Observations of the shared bathroom in rooms 218 and 220 on 03/13/17 at 1:36 PM revealed the inside of both bathroom doors and the wall in front of the toilet were scratched. The subsequent observations were on 03/14/17 at 8:17 AM and 03/16/17 at 5:04 PM in which the conditions

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F 253	Continued From page 14 remained unchanged. d. Observations of the shared bathroom in rooms 221 and 223 on 03/13/17 at 1:52 PM revealed the inside of both bathroom doors and the wall in front of the toilet were scratched. In addition, observations of room 221 revealed the vinyl on the overbed table edge was peeled back which left sharp edges. The subsequent observations were on 03/14/17 at 8:19 AM and 03/16/17 at 5:04 PM in which the conditions remained unchanged. e. Observations in bedroom 223 on 03/13/17 at 8:51 AM revealed the bedroom door had gouged out wood areas on the hinge side of the door. The subsequent observations were on 03/14/17 at 8:19 AM and 03/16/17 at 5:06 PM in which the conditions remained unchanged. f. Observations of the shared bathroom in rooms 225 and 227 on 03/14/17 at 11:49 AM revealed the inside of both bathroom doors were scratched. In addition, observations of the entry door for room 227 revealed the hinge side of the bedroom door had gouged out wood areas on it. The subsequent observations were on 03/16/17 at 8:17 AM and 03/16/17 at 5:11 PM in which the conditions remained unchanged. g. Observations of the shared bathroom in rooms 226 and 228 on 03/13/17 at 3:28 PM revealed the inside of both bathroom doors and the wall in front of the toilet were scratched. In addition, observations for the entry door for room 228 revealed the hinge side of the door had gouged out wood areas on it. The subsequent observations were on 03/14/17 at 8:39 AM and 03/16/17/at 5:13 PM in which the conditions	F 253		

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remained unchanged.

h. Observations of the shared bathroom in rooms 229 and 231 on 03/13/17 at 8:48 AM revealed the inside of both of the bathroom doors and the wall in front of the toilet were scratched. In addition, observations of the entry door for room 231 revealed both edges of the door had gouged out wood areas on it. The subsequent observations were on 03/14/17 at 8:57 AM and 03/16/17 at 5:14 PM in which the conditions remained unchanged.

An interview conducted with the Maintenance Director on 03/16/17 at 4:19 PM in which he revealed he performed routine weekly audits on call lights, monthly audits on hand rails, lifts and (Resident) rooms, and the side rails were checked twice a month. The Maintenance Director stated that repair requisitions were left on clip boards that were kept on both sides of the building and were checked several times a day. The Maintenance Director stated that he would have to putty the gouged out areas in the doors, paint the bathroom walls and he agreed that the sharp edges on the over bed tables could cause skin tears.

4. a. Observations of the shared bathroom in rooms 210 and 212 on 03/15/17 at 10:42 AM revealed an uncovered black plunger on the floor next to the toilet as well as an unlabeled and uncovered graduated cylinder on the back of the toilet. The subsequent observations were on 03/16/17 at 8:11 AM and at 3:02 PM in which the conditions remained unchanged.

An interview was conducted with the Director of Nursing (DON) on 03/16 17 at 3:02 PM in which

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she stated the plunger should be in a tied bag and the graduated cylinder should be labeled and in a bag on the back of the toilet.
5. a. Observations of a shared sink for room 208 on 03/13/17 at 4:34 PM, 03/15/17 at 4:21 PM, and 03/16/17 at 3:01 PM revealed an unlabeled and un-bagged: toothbrush, tube of toothpaste, bottle of mouthwash, and bottle of shampoo.

b. Observations of a shared sink for room 223 on 03/14/17 at 8:42 AM, 03/15/17 at 5:05 PM, and 03/16/17 at 3:04 PM revealed an unlabeled and un-bagged tooth brush, tooth paste, and a bottle of shampoo.

c. Observations of a shared sink for room 218 on 03/14/17 at 9:50 AM, 03/15/17 at 4:59 PM, and 03/16/17 at 3:30 PM revealed an unlabeled and un-bagged denture cup, bottle of perineal care, and shampoo.

Interview with the Director of Nursing (DON) on 03/16/17 at 3:20 PM revealed personal care items should not be stored on the back of the sink unlabeled. The DON stated she preferred personal care items be in a labeled zip top bag and for tooth brushes not to be uncovered.

6. a. Observations of the entrance door for room 207 on 03/15/17 at 4:30 PM and 03/16/17 at 4:30 PM revealed broken and splintered laminate and wood on both edges of the bottom half of the door.

b. Observations of the entrance door for room 211 on 03/13/17 3:27 PM, 03/15/17 at 4:54 PM, and 03/16/17 at 4:41 PM revealed broken and splintered laminate and wood on both edges of the bottom half of the door.

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c. Observations of the entrance door for room 217 on 03/15/17 at 4:52 PM and 03/16/17 at 4:52 PM revealed broken and splintered laminate and wood on both edges of the bottom half of the door.

d. Observations of a shared bathroom door for room 218 on 03/14/17 at 9:50 AM, 03/15/17 at 4:59 PM, and 03/16/17/at 4:59 PM revealed splintered wood along the lower portion of the door.

e. Observations of a shared bathroom door for room 223 on 03/14/17 at 8:42 AM, 03/15/17 at 5:05 PM, and 03/16/17 at 5:06 PM revealed splintered wood along the lower portion of the door.

An interview conducted with the Maintenance Director on 03/16/17 at 5:30 PM revealed the splintered wood could cause injury to the residents and they would need to fill in the splintered edges of the door with wood putty and sanded until a decision was made about replacing the doors or a better solution was found.

An interview with the Administrator on 03/16/17 at 5:52 PM in which she revealed the facility was trying to decide whether to use coverings or replace the doors. She agreed the splintered doors was a potential for injury and there needed to be a solution.

7. a. Observations of the shared bathroom for rooms 314 and 316 made on 03/13/17 at 2:30 PM, 03/14/17 at 12:04 PM, 03/15/17 at 9:38 AM,

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F 253	Continued From page 18 03/16/17 at 8:24 AM and 03/16/17 at 5:19 PM revealed an area measuring approximately 4 inches wide by 12 inches long with the top layer of drywall missing located above and to the right of the sink. b. Observations of the shared bathroom for rooms 323 and 325 made on 03/13/17 at 4:23 pm, 03/14/17 at 11:56 AM, 03/15/17 at 9:40 AM, 03/16/17 at 8:23 AM, 03/16/17 at 2:53 PM and 03/16/17 at 5:36 PM revealed an area measuring approximately 5 inches wide by 5 inches long with the top layer of drywall missing located above the soap dispenser. An interview with the Maintenance Director on 03/16/17 at 5:36 PM revealed he and his assistant completed a full audit of the 300 hall in January 2017 and had just finished the list in February 2017. The Maintenance Director was unable to recall if these 2 bathrooms were on the list. 8. Observations of the shared bathroom for rooms 314 and 316 made on 03/13/17 at 2:30 PM, 03/14/17 at 12:04 PM, 03/15/17 at 9:38 AM, 03/16/17 at 8:24 AM and 03/16/17 at 5:19 PM revealed an unlabeled and unbagged tube of toothpaste on the bathroom sink. An interview with the Director of Nursing (DON) on 03/16/17 at 3:20 PM revealed residents' personal care items should not be stored on the back of the sink unlabeled. The DON stated she preferred for personal items to be stored in a labeled zip top bag.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		4/13/17

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(b) Comprehensive Assessments

(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and

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F 272	Continued From page 20 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the contributing factors and risk factors for 1 of 3 sampled residents reviewed for vision (Resident #81). The findings included: Review of the medical record revealed Resident #81 was admitted on 03/24/15 with diagnoses including dementia. Review of the annual Minimum Data Set (MDS) dated 02/15/17 revealed Resident #81 had moderately impaired cognition and could see large print but not regular print in newspapers and books. The annual MDS also noted Resident #81 did not use corrective lenses. Review of the Care Area Assessment (CAA) for Vision completed with the annual assessment revealed Resident #81 was being monitored by the eye clinic for cataracts and was seen on 07/25/16 and there were no real changes from last update. The CAA noted Resident #81 did not need to be seen by the eye clinic again until 07/2017. The CAA summary and analysis of findings did not include her strengths and weaknesses or how the triggered area impacted	F 272	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Care Area Assessment for resident #81 was updated to reflect her description of the problem, possible causes and contributing factors and risk factors related to Visual function on April 5, 2017. How the facility will identify other residents having the potential to be affected by the same deficient practice? All resident Care Area Assessments for vision will be audited by the MDS Coordinator to insure their visual functioning has been captured appropriately. This will occur by April 13, 2017. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Director of Social Services was in-serviced on completion of the Care Area Assessment by the MDS	

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F 272	Continued From page 21 her day to day life. There was no mention of how the vision loss affected her safety, participation in social activities, or self-care activities. An interview was conducted with the Social Worker (SW) on 03/15/17 at 4:46 PM. The SW stated she had been completing MDS assessments for a very long time and was responsible for several sections including the vision section. Resident #81's CAA Summary for Vision was reviewed during the interview and the SW indicated she usually referred to the date of her progress note in the analysis of findings. The SW further stated the progress note contained resident specific information including how the triggered area affected the resident's day to day life. The SW was not sure why she did not refer to her progress note in the CAA or analysis of findings.	F 272	Coordinator on March 28, 2017. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or MDS Coordinator will audit Care Area Assessments for Vision with 2 weekly x 4 weeks, then 1 weekly x 4 weeks, then 2 monthly x 6 months. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or MDS Coordinator will audit Care Area Assessments for Vision with 2 weekly x 4 weeks, ten 1 weekly x 4 weeks, then 2 monthly x 6 months. The Director of Nursing will report the findings to the Quality Assurance Performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a certified nursing assistant meeting monthly x 8 months for follow up and/or recommendations.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		4/13/17

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F 281	Continued From page 22 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to rinse a resident's mouth with water after administering an inhaler to reduce the chance of a fungal infection for 1 of 5 residents observed during medication administration (Resident #53). The findings including: Resident #53 was admitted on 08/08/13 with diagnoses including chronic obstructive pulmonary disease (COPD). Review of Physician's orders revealed Resident #53 was prescribed Symbicort inhaler (contains a steroid and bronchodilator) 160-4.5 mcg (micrograms) inhale 2 puffs orally twice a day for COPD. Observations of medication administration on 03/14/17 at 4:18 PM revealed Nurse #2 prepared Resident #53's medications including a Symbicort inhaler 160-4.5 mcg. Nurse #2 entered Resident #53's room at approximately 4:20 PM and administered oral medications and then the Symbicort inhaler waiting several minutes between inhalations. Nurse #2 exited Resident #53's room at approximately 4:35 PM.	F 281	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The Medication Administration Record for resident #53 was updated to include instructions to rinse and spit after Symbicort inhaler use on March 14, 2017. How the facility will identify other residents having potential to be affected by the same deficient practice. Any resident receiving a steroid inhaler will be audited by a licensed nurse and ensure their orders include rinsing and spitting after inhaler use by April 13, 2017. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur? 100% of licensed nurses (including the nurse who did not provide a rinse) were in-serviced about rinsing mouth and spitting out after any steroid inhaler use by March 17, 2017, by the Director of Nursing or the Staff Development	

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F 281	Continued From page 23 During an interview on 03/14/17 at 4:47 PM Nurse #2 was asked if there was anything she did after administering a Symbicort inhaler to a resident. Nurse #2 stated she thought she was supposed to have the resident rinse their mouth with water to prevent a yeast infection. Nurse #2 confirmed she did not have Resident #53 rinse her mouth with water after administering the Symbicort inhaler. An interview with the Pharmacist on 03/15/16 at 3:06 PM revealed she expected nurses to have residents rinse their mouth with water and spit after administering a Symbicort inhaler because it contains a steroid and to reduce the chance of a fungal infection (thrush). An interview with the Director of Nursing (DON) on 03/16/17 at 8:41 AM revealed nurses were expected to have residents rinse their mouth with water and spit after administering an inhaler that contained a steroid such as Symbicort. The DON confirmed Resident #53 would be able to rinse her mouth with water and spit without any difficulty.	F 281	Coordinator. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will complete five random medication passes of licensed nurse observations to include all shifts weekly x 4 weeks, then 3 random licensed nurse observations to include all shifts weekly x 4 weeks, then 1 random licensed nurse observation to include all shifts weekly x 6 months. New hire nurses will be in-serviced during their orientation period. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will present findings of random medication observations with licensed nurses during the monthly Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and certified nursing assistant monthly for follow-up and/or recommendations x 8 months.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		4/13/17

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F 282	Continued From page 24 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a care planned intervention for routine dental services for 1 of 3 sampled residents reviewed for dental status and services (Resident #110). The findings included: Review of the medical record revealed Resident #110 was admitted on 06/24/16 with diagnoses including Alzheimer's disease. Review of the admission Minimum Data Set (MDS) dated 07/03/16 revealed Resident #110 had severely impaired cognition and had obvious or likely cavity or broken natural teeth. Review of the Care Area Assessment (CAA) Summary for Dental Care completed with the admission MDS revealed Resident #110 was at risk for mouth pain and problems chewing due to broken and missing teeth. The CAA Summary noted Resident #110 consumed 68% to 83% of her regular diet and did not have any complaints of pain or problems chewing at that time. Review of a care plan dated 11/10/16 revealed Resident #110 had the potential for mouth pain	F 282	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? a. Dental appointment is scheduled for resident #110 on the earliest available appointment. The Nurse Practitioner is aware and is agreement with the appointment schedule. How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident charts were audited for last dental appointment. The audit was completed on April 5, 2017 by a Licensed Nurse. The audit was to ensure all residents dental appointments have not been missed and follow up occurred. Those residents found to have missed dental appointments will have appointments made by the Social Services Director. What measure will be put in place or systemic changes made to ensure that	

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F 282	Continued From page 25	F 282		

and problems chewing due to missing and broken teeth. The goal was to ensure dental health by means of the dentist through next review on 09/28/16 and 02/17/17. Interventions included: extractions as ordered by the dentist, report oral pain or difficulty chewing food, obtain a dental consult and follow through, ensure complete repair of carious teeth, and in house dentist per facility protocol.

An interview with MDS Nurse #1 on 03/16/17 at 8:56 AM revealed when she completed an MDS assessment and determined a resident required a dental consult she typically communicated this information to the Social Worker (SW) verbally during the daily Interdisciplinary Team (IDT) meeting. MDS Nurse #1 reviewed Resident #110's admission MDS assessment dated 07/03/16 and noted it had been completed by MDS Nurse #2.

During an interview on 03/16/17 at 9:02 AM MDS Nurse #2 confirmed she completed Resident #110's admission MDS assessment dated 07/03/16 including the Oral/Dental Status section. MDS Nurse #2 stated Resident #110 had broken and missing teeth but denied pain. MDS Nurse #2 explained when she determined a resident required a dental consult she typically communicated this information to the Social Worker (SW) verbally during the daily IDT meeting or went by her office. MDS Nurse #2 further stated she had told the SW Resident #110 needed to be seen by the Dentist but was not certain when because there was no documentation of when the request was made.

An interview was conducted with the SW on 03/16/17 at 9:04 AM. The SW stated MDS Nurse

the deficient practice will not recur?

100% of staff will be in-serviced on dental referrals or need of referral of any dental concerns to licensed nurse. Also, included is referral of dental needs in writing to Social Services Director and Physician. The in-servicing will be completed by April 13, 2017, by the Staff Development Coordinator, Director of Nursing or Assistant Director of Nursing. All new hires will be in-serviced upon hire.

Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will randomly audit 2 MDS (Section L) x one week for a month, 1 MDS (Section L) x one week for one month and two random MDS (Section L) x month for nine months.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will present the results of MDS (Section L) audit to the monthly Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary

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F 282	Continued From page 26 #1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated the Dentist came to the facility quarterly and the last visit was on 01/23/17 and the next scheduled visit was on 03/29/17. The SW reviewed her lists of who had been seen by the Dentist on 01/23/17 and which residents were scheduled to be seen on 03/29/17 and confirmed Resident #110 was not on either list. The SW indicated she had not been informed Resident #110 needed to be seen by the Dentist and she was not aware of any dental problems. During an interview on 03/16/17 at 1:27 PM the Director of Nursing (DON) stated the SW took care of referrals to the Dentist and she expected the MDS Nurses to communicate any dental concerns that were identified during the MDS assessment to the SW. The DON explained this information was usually communicated verbally during the daily morning stand up meeting. The DON could not explain why Resident #110 was not referred to the Dentist and stated the facility needed to change their process to ensure residents were referred to Dentist when they had dental issues.	F 282	Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a certified nursing assistant meeting monthly to for further follow up and/or recommendations x 9 months. Any aberrancies will be addressed, interventions developed and corrective actions taken.	
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		4/13/17

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F 323	Continued From page 27 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure bed rails were secured safely for 4 of 4 residents reviewed for accidents (Residents #32, #44, #97, and #126). Findings Included: 1. Review of the medical records revealed Resident #32 was admitted to the facility on 12/15/10 with diagnoses including anxiety, depression, and dementia. Review of quarterly Minimum Data Set (MDS) dated 02/06/17 revealed Resident #32 had moderately impaired cognition. The quarterly MDS implied Resident #32 needed extensive assist with bed mobility and transfers and walking	F 323	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The Maintenance Director tightened the rails for residents #32, #44, #97 and #126 on March 16, 2017. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with rails have the potential to be affected. The residents with side rails will have their beds audited and adjustments will be made to their beds as	

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F 323	Continued From page 28 did not occur. Review of the care plan for Resident #32 with a revised date of 02/20/17 focused on the potential for falls due to poor safety awareness and non-ambulatory status related to debility. The interventions were to keep the call light within reach and use a mechanical lift for transfers and to keep the bed in low position. An observation of Resident #32 side rail was made on 03/13/17 at 2:14 PM, 03/16/17 at 3:16 PM, and 03/16/17 at 4:34 PM revealed the right quarter rail at the head of the bed to be loose with the ability to move from side to side approximately 3 inches from the bed frame and mattress. There was no rail on the left side of the bed. The Maintenance Director was accompanied to Resident #32's room on 03/16/17 at 4:34 PM to observe the side rails and confirmed the rails were loose and not acceptable and needed to be tightened or replaced. The Maintenance Director confirmed side rails were checked twice a month. An interview with NA #1 on 03/16/17 at 5:07 PM revealed Resident #32 possibly could grab the side rail, but was unsure of the ability to turn or roll while in the bed. NA #1 revealed direct care staff used a mechanical lift to transfer Resident #32. An interview with the Administrator on 03/16/17 at 5:55 PM confirmed the loose side rails needed to be addressed and immediately fixed. 2. Review of the medical records revealed Resident #44 was admitted to the facility on	F 323	necessary for safety by April 13, 2017. What measure will be put in place or systemic changes made to ensure the deficient practice will not recur? Maintenance Director, Assistant Maintenance Director, Environmental Services Supervisor, Director of Nursing, Assistant Director of Nursing or Administrator will audit rails for proper attachment to the bed and will tighten as needed. This will be completed by April 13, 2017. 100% of staff will be educated on bed rail safety. The in-service includes checking for loose rails, completion of work orders if repair or adjustment is needed. If after hours, then replacement of resident's bed until adjustment/repair can be made. The in-service will be completed by the Staff Development Coordinator by April 13, 2017. The Maintenance Director, Maintenance Assistant, Environmental Services Supervisor, Director of Nursing, Assistant Director of Nursing or Administrator will audit all beds with rails weekly for a month, bi-weekly for a month and monthly x 3 months. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.	

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F 323	Continued From page 29 10/19/12 with diagnoses including dementia and cerebral infarction. Review of the quarterly Minimum Data Set (MDS) dated 02/15/17 revealed Resident #44 was cognitively intact and needed extensive assist with bed mobility and transfers. An observation of Resident #44 side rails was made on 03/14/17 at 10:05 AM, 03/15/17 at 8:43 AM, and 03/16/17 at 4:18 PM revealed two quarter rails at the head of the bed to be loose with the ability to move from side to side approximately 3 inches from mattress. An interview with NA #1 confirmed Resident #44 was able to use the grab bars for bed mobility. NA #1 indicated Resident #44 had been sick, but is getting better and regaining his strength. The Maintenance Director was accompanied to Resident #44's room on 03/16/17 at 4:59 PM to observe the side rails and confirmed the rails were loose and not acceptable and needed to be tightened or replaced. The Maintenance Director confirmed side rails were checked twice a month. An interview with the Administrator on 03/16/17 at 5:55 PM confirmed the beds with loose side rails needed to be addressed and immediately fixed. 3. Review of the medical records revealed Resident #126 was admitted on 03/01/17 with dx of cerebral palsy. There was no Minimum Data Set or comprehensive care plan available for review. An observation of the bed rails for Resident #126 was done on 03/14/17 at 8:56 AM and 03/16/17	F 323	The Maintenance Director will present the results of the bed rail audit at the Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge Nurse and a certified nursing assistant monthly x 5 months for further follow-up and/or recommendations.	

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F 323	Continued From page 30 at 5:06 PM revealed two quarter rails at the head of the bed moved from side to side approximately 3 inches from mattress. An interview with NA #1 confirmed Resident #126 had the ability to use the bed rails for bed mobility. The Maintenance Director was accompanied to Resident #126's room on 03/16/17 at 5:06 PM to observe the side rails and confirmed the rails were loose and not acceptable and needed to be tightened or replaced. The Maintenance Director confirmed side rails were checked twice a month. An interview with the Administrator on 03/16/17 at 5:55 PM confirmed the beds with loose side rails needed to be addressed and immediately fixed. 4. Review of the medical record revealed Resident #97 was admitted on 10/01/15 with diagnoses including hemiplegia following cerebral infarction affecting dominant side and vascular dementia. Review of a care plan dated 02/15/16 revealed Resident #97 had the potential for falls due to an unsteady gait and left sided weakness. Interventions included: keep call bell in easy reach and answer in a timely manner, 1 to 2 assist with transfer, and encourage and remind Resident #97 to ask for assistance with transfer.	F 323		

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The care plan was updated on 06/23/16 to include changing the bed side rail to the right side of the bed. This care plan was due to be reviewed again on 06/23/16.

Review of the annual Minimum Data Set (MDS) dated 01/29/17 revealed Resident #97 had moderately impaired cognition and required extensive assistance with bed mobility and transfer.

Review of a side rail assessment dated 02/09/17 noted Resident #97 had alterations in safety awareness due to cognitive decline and had demonstrated poor bed mobility or difficulty moving into a sitting position on the side of the bed. The assessment concluded Resident #97 was currently using the the side rail for positioning or support and indicated it served as an enabler to promote independence.

Observations of Resident #97's right side 1/2 rail on her bed on 03/14/17 at 11:31 AM, 03/15/17 at 9:47 AM, and 03/16/17 at 2:51 PM revealed the right side 1/2 rail was loose and when the rail was grasped it moved up and down approximately 2 inches and could be pulled away from the bed frame leaving approximately 2 to 3 inches of space between the mattress and the side rail.

An interview with Resident #97 on 03/16/17 at 8:50 AM revealed she used the side rail on her bed for turning and repositioning in bed and getting out of bed. Resident #97 indicated she had not noticed the side rail on her bed was loose.

During an interview on 03/16/17 at 4:09 PM Nurse Aide (NA) #2 stated Resident #97 used the

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F 323	Continued From page 32 side rail on her bed for bed mobility and transfers. The interview further revealed when NA #2 noticed loose side rails he turned the knob to tighten them down. An interview with the Maintenance Director on 03/16/17 at 4:19 PM revealed there were work order forms on a clip board at both nurse's stations for staff to write down repairs and he and his assistant checked the clip boards several times a day. The Maintenance Director further stated side rails were checked twice a month. On 03/16/17 at 5:34 PM the Maintenance Director was accompanied to Resident #97's room to observe the right side 1/2 rail and stated the loose side rail was not acceptable. The Maintenance Director further stated the side rail was missing a spacer that would make it tighter and if this did not work the side rail would be replaced. During an interview on 03/16/17 at 5:55 PM the Administrator stated she did not approve of loose side rails and they would need to be fixed immediately.	F 323		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;	F 411		4/13/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 411	Continued From page 33 (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide routine dental services for 1 of 3 sampled residents reviewed for dental status and services (Resident #110). The findings included: Review of the medical record revealed Resident #110 was admitted on 06/24/16 with diagnoses including Alzheimer's disease. Review of the admission Minimum Data Set (MDS) dated 07/03/16 revealed Resident #110 had severely impaired cognition and had obvious or likely cavity or broken natural teeth. Review of the Care Area Assessment (CAA) Summary for Dental Care completed with the admission MDS revealed Resident #110 was at risk for mouth pain and problems chewing due to broken and missing teeth. The CAA Summary noted Resident #110 consumed 68% to 83% of her regular diet and did not have any complaints of pain or problems chewing at that time. Review of a care plan dated 11/10/16 revealed	F 411	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? a. Dental appointment is scheduled for resident #110 on the earliest available appointment. The Nurse Practitioner is in agreement with the available scheduled appointment. How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident charts were audited for last dental appointment. The audit was completed on April 5, 2017, by a licensed nurse. The audit was to ensure all residents dental appointments have not been missed and follow up occurred. Those residents found to have missed dental appointments will have appointments made by the Social Services Director.	

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	345285	A. BUILDING _____ B. WING _____	03/16/2017

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F 411	Continued From page 34 Resident #110 had the potential for mouth pain and problems chewing due to missing and broken teeth. The goal was to ensure dental health by means of the dentist through next review on 09/28/16 and 02/17/17. Interventions included: extractions as ordered by the dentist, report oral pain or difficulty chewing food, obtain a dental consult and follow through, ensure complete repair of carious teeth, and in house dentist per facility protocol. An interview with MDS Nurse #1 on 03/16/17 at 8:56 AM revealed when she completed an MDS assessment and determined a resident required a dental consult she typically communicated this information to the Social Worker (SW) verbally during the daily Interdisciplinary Team (IDT) meeting. MDS Nurse #1 reviewed Resident #110's admission MDS assessment dated 07/03/16 and noted it had been completed by MDS Nurse #2. During an interview on 03/16/17 at 9:02 AM MDS Nurse #2 confirmed she completed Resident #110's admission MDS assessment dated 07/03/16 including the Oral/Dental Status section. MDS Nurse #2 stated Resident #110 had broken and missing teeth but denied pain. MDS Nurse #2 explained when she determined a resident required a dental consult she typically communicated this information to the Social Worker (SW) verbally during the daily IDT meeting or went by her office. MDS Nurse #2 further stated she had told the SW Resident #110 needed to be seen by the Dentist but was not certain when because there was no documentation of when the request was made. An interview was conducted with the SW on	F 411	What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur? 100% of staff will be in-serviced on dental referrals or need of referral of any dental concerns to licensed nurse. Also, included is referral of dental needs in writing to Social Services Director and Physician. The in-servicing will be completed by April 13, 2017, by the Staff Development Coordinator, Director of Nursing or Assistant Director of Nursing. All new hires will also be in-serviced upon hire. Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will randomly audit 2 MDS (Section L) x one week for a month, 1 MDS (Section L) x one week for one month and two random MDS (Section L) x month for nine months. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will present the results of MDS (Section L) audit to the monthly Quality Assurance Performance Improvement Committee meeting consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), Staff Development Coordinator, MDS	

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F 411	Continued From page 35 03/16/17 at 9:04 AM. The SW stated MDS Nurse #1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated the Dentist came to the facility quarterly and the last visit was on 01/23/17 and the next scheduled visit was on 03/29/17. The SW reviewed her lists of who had been seen by the Dentist on 01/23/17 and which residents were scheduled to be seen on 03/29/17 and confirmed Resident #110 was not on either list. The SW indicated she had not been informed Resident #110 needed to be seen by the Dentist and she was not aware of any dental problems. During an interview on 03/16/17 at 1:27 PM the Director of Nursing (DON) stated the SW took care of referrals to the Dentist and she expected the MDS Nurses to communicate any dental concerns that were identified during the MDS assessment to the SW. The DON explained this information was usually communicated verbally during the daily morning stand up meeting. The DON could not explain how Resident #110 was not referred to the Dentist and stated the facility needed to change their process to ensure residents were referred to Dentist when they had dental issues.	F 411	Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a certified nursing assistant meeting monthly to for further follow up and/or recommendations x 9 months. Any aberrancies will be addressed, interventions developed and corrective actions taken.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		4/13/17

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F 520	Continued From page 36 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the Quality Assessment and Assurance Committee of the facility failed to	F 520	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged	

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F 520	Continued From page 37 maintain procedures and monitor the inventions put in place by the committee in December 2015. This was for 2 deficiencies originally cited in December 2015 and cited again during a recertification survey in March 2017. The deficiencies were in the areas of choices and housekeeping and maintenance. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings Included: This tag is cross referenced to: F242: The right to make choices was cited in December 2015. Based on medical record review, and resident and staff interviews, the facility failed to allow residents to make choices regarding wake times and bath/shower preferences that were significant to the resident for 2 of 3 residents reviewed for choices (Resident #50 and Resident #132). During the recertification survey of March 2017 the facility was cited for F242 for failing to provide smoking residents the opportunity to demonstrate the ability to independently smoke. Based on observations, record reviews, staff and resident interviews the facility failed to provide 2 of 7 sampled residents the opportunity to demonstrate the ability to safely smoke (Residents #33 and #59). F 253: Housekeeping and Maintenance Services was cited in December 2015. Based on observations, medical record review and interviews with residents and staff the facility failed to address maintenance concerns in 6 resident rooms on 2 of 2 halls in the facility	F 520	deficient practice? The Vice President of Clinical Services will in-service the Quality Assurance Committee members including: Administrator, Director of Nursing, Business Office Manager, Social Services Director, Human Resource Director, Medical Records, Minimum Data Set Coordinator, Restorative Nurse, Admissions Director, Dietary Manager, Activity Director, Environmental Services Supervisor, Maintenance Director by April 13, 2017, on the Quality Assessment and Assurance Committee Policy. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents have the potential to be affected. b. The Vice President of Clinical Services will in-service the Quality Assurance Committee on the Quality Assessment and Assurance Committee policy during a scheduled telephone training by April 13, 2017. The team will be in-serviced on presenting information regarding any systems breakdown and when issues are identified that are related to failure to follow the facility policy and/or trends are identified, action plans will be implemented to prevent deficiencies from recurring. What measure will be put in place or systemic changes made to ensure the deficient practice will not recur?	

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F 520	Continued From page 38 (Residents #117, #132, #105, #30, #122 and #27). During the recertification survey of March 2017 the facility was cited for failing to address repair and maintenance concerns. Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate on 8 of 62 room entry doors on 2 of 2 wings (Resident room #207, #211, #217, #223, #227, #228, #231, and #308. The facility also failed to repair broken and splintered laminate on 2 of 29 shared bathroom doors on 1 of 2 wings (Resident room #218 and #223), replace over-bed tables with missing or peeling vinyl in 3 rooms on 2 of 2 wings (Resident room #217, #221, and #306), replace cracked and discolored caulking at the base of toilets, keep bathroom doors free of scratches, paint scratched bathroom walls, repair dry wall, and remove stains from a bathroom floor for 12 of 29 shared bathrooms on 2 of 2 wings. In addition, the facility also failed to label and properly store personal hygiene products, personal care equipment, and plungers on 2 of 2 wings. An interview with Administrator on 03/16/17 at 7:01 PM revealed her understanding was the plan of correction for December 2015 had been addressed and corrected. The new concerns identified for the choice to independently smoke, housekeeping and maintenance were not related.	F 520	a. The Vice President of Clinical Services will in-service the Quality Assurance Committee on the Quality Assessment and Assurance Committee Policy during a scheduled telephone training by April 13, 2017. The team will be in-serviced on presenting information regarding any systems breakdown and when issues are identified that are related to failure to follow the facility policy and/or trends are identified, action plans will be implemented to prevent deficiencies from recurring. b. The facility Quality Assurance Committee will hold its regularly scheduled monthly meeting on April 25, 2017. Included in this meeting will be a review of audits and in-services pertaining to the recent survey. All monitoring tools and documentation for all tags cited will be reviewed during the meeting. c. A new stand up morning meeting form is being utilized and filled out by the Administrator or Director of Nursing to discuss monitoring tools for compliance. The form is comprehensive in nature and includes survey tag monitoring for compliance, ensuring current monitoring tools completed for survey compliance, policies under review, admissions and resident concerns, How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.	

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F 520	Continued From page 39	F 520	The Regional Vice President and/or Vice President of Clinical Services will review the Quality Assurance Performance Improvement Meeting minutes monthly for three months to ensure all required items are included and that the Quality Assurance Committee has addressed issues that were identified with implementation of policies and procedures, in-servicing, performance improvement plans and monitoring tools.	