STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 No deficiencies were cited as a result of the complaint investigation Event ID #IK5611.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide OBRA (Omnibus Budget Reconciliation ACT) Minimum Data Set (MDS) assessments every 92 days for 1 of 22 residents' MDS assessments reviewed (Resident #56). The findings included: Resident #56 was admitted to the facility 11/29/17. A review of MDS assessments revealed an admission MDS assessment dated 12/06/17 was the last OBRA assessment completed for Resident #56. Continued MDS assessment review revealed Resident #56 was admitted to the hospital 02/06/18 and returned to the facility 02/13/18. An additional hospital admission was noted 03/13/18 with return to the facility 03/15/18. An interview was conducted with the MDS Coordinator 04/18/18 at 10:50 AM. The MDS Coordinator stated Resident #56 had been admitted to the hospital 02/06/18 and 03/13/18. She counted the days the resident was in the hospital with each hospitalization and determined	F 638	1. Resident #56 is currently a resident in the facility and was last hospitalized March 13, 2018 and was readmitted on March 15, 2018. The cause of the deficient practice was that the MDS Coordinator opened a Significant Change of Status Assessment for March 22, 2018. Significant status was not complete because of no changes in two or more areas from prior assessment. The MDS Coordinator failed to change and open the assessment for a Quarterly Assessment. Resident #56 had a Quarterly OBRA MDS Assessment which was completed, transmitted and accepted on April 18, 2018. Resident #56 is currently up to date the assessment schedule. 2. MDS Coordinator was educated by the DON on the importance of completing the assessments accurately and in a timely manner.MDS Coordinator will review the OBRA Quarterly Assessments on a weekly basis beginning on May 11, 2018 and ongoing through August 8, 2018 3.The MDS Corporate Nurse Consultant	5/14/18

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

Electronically Signed | 05/11/2018

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F 638	Continued From page 1 that number was a total of 15 days. The MDS Coordinator further determined a quarterly OBRA MDS assessment was due 04/10/18. She stated when the resident returned to the facility from the 03/13/18, she thought a comprehensive significant change assessment would be required. When assessed, the resident was found at his original baseline. Therefore no significant change was required. The MDS Coordinator added she overlooked the quarterly OBRA assessment due 04/10/18. During an interview on 04/18/18 at 2:19 PM, the Director of Nursing stated she expected MDS assessments were completed within the required 92 days.	F 638	will review Assessments for accuracy and transmission in a timely manner as required by CMS, bi-weekly beginning on May 14,2018 and ongoing. 4. The Director of Nursing and the Executive Director are responsible for implementing the Plan of Correction.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident	F 640		5/14/18

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F 640	Continued From page 2 contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit a discharge Minimum Data Set (MDS) assessment for 2 of 2 residents reviewed for discharge (Resident #1 and Resident #2). Findings included: 1. Resident #1 was admitted to the facility on	F 640	1. The cause of the deficiency was a lack of system to review the assessment completion. Complete Care has a hired a MDS Corporate Nurse Consultant to create a system for accurate and timely transmissions. 2. Residents #1 and #2 have both been discharged from the facility.The discharge assessment for Resident #1 was	

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F 640	Continued From page 3 11/22/17. A review of a physician's order dated 01/23/18 indicated Resident #1 was to be discharged from the facility with home health and skilled nursing on 01/24/18. A review of the Discharge/Transition Plan indicated Resident #1 had a planned discharge from the facility on 01/24/18. A review of a nurse's note dated 01/24/18 indicated Resident #1 was discharged home with family. A review of the completed MDS assessments revealed no discharge MDS assessment was completed and transmitted for Resident #1. On 04/18/18 at 10:24 AM an interview was conducted with the MDS Coordinator who stated Resident #1 had a planned discharge from the facility on 01/24/18. The MDS Coordinator stated she forgot to complete the MDS discharge assessment for Resident #1 that was due to be completed and transmitted by 02/07/18. The MDS Coordinator stated completing Resident #1's discharge MDS assessment was not a priority because the facility did not receive reimbursement. The MDS Coordinator stated she may have been busy with completing admission assessments for other residents and overlooked that Resident #1's discharge MDS assessment was due by 02/07/18. The MDS Coordinator stated she was responsible for transmitting Resident #1's discharge MDS assessment. The MDS Coordinator stated she would need to complete Resident #1's discharge MDS assessment immediately and transmit.	F 640	completed, transmitted and accepted on April 18, 2018.The discharge Assessment for Resident #2 was completed, transmitted and accepted on April 18, 2018. MDS Coordinator was educated by the DON on the importance of encoding and transmitting data accurately and in a timely manner. Residents who have Admission, Annual, Significant changes and Quarterly Assessments will be reviewed daily during clinical stand-up. The MDS Coordinator will notify the DON or Nursing designee to ensure that assessments are completed accurately and in a timely manner.The new system is as follows. The MDS Coordinator and Business Office Manager will review the admissions and discharges on a weekly basis. MDS Corporate Nurse Consultant will be notified of discharges every Thursday by the facility MDS Coordinator. 3. Director of Nursing will review discharge assessments weekly beginning on May 17, 2018. The MDS Corporate Nurse Consultant will review Assessments for accuracy and transmission in a timely manner as required by CMS, bi-weekly beginning on May 14, 2018. 4. The Director of Nursing and the Executive Director are responsible for implementing the Plan of Correction.	

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F 640	Continued From page 4 On 04/18/18 at 10:34 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the MDS Coordinator would have completed Resident #1's MDS discharge assessment by 02/07/18. The DON stated the MDS Coordinator attended morning meetings and resident discharges were discussed therefore the MDS Coordinator should have completed and transmitted Resident #1's discharge MDS assessment timely. The DON stated her expectation was that the MDS Coordinator would immediately complete a discharge MDS assessment on Resident #1 and transmit. On 04/18/18 at 10:40 AM an interview was conducted with the Administrator who stated her expectation was that the MDS Coordinator would have completed Resident #1's discharge MDS assessment by 02/07/18. The Administrator stated all MDS assessments were due timely and not based on financial priority. The Administrator stated her expectation was that the MDS coordinator would immediately complete a discharge MDS assessment for Resident #1 and transmit. 2. Resident #2 was admitted to the facility on 09/14/17. A review of a physician's order dated 01/26/18 indicated Resident #2 was to be discharged home on 01/26/18. A review of the physician's discharge summary dated 01/26/18 indicated Resident #2 was discharged on 01/26/18.	F 640		

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F 640	Continued From page 5	F 640		

A review of the Discharge/Transition Plan indicated Resident #2 had a planned discharge from the facility on 01/26/18.

A review of the completed MDS assessments revealed no discharge MDS assessment was completed and transmitted for Resident #2.

On 04/18/18 at 12:58 PM an interview was conducted with the MDS Coordinator who stated Resident #2 was discharged from the facility on 01/26/18. The MDS Coordinator stated she was responsible for completing and transmitting Resident #2's discharge MDS assessment by 02/09/18 and forgot to complete and transmit the assessment. The MDS Coordinator stated she would need to complete Resident #2's discharge MDS assessment immediately and transmit.

On 04/18/18 at 1:05 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the MDS Coordinator would have completed Resident #2's MDS discharge assessment by 02/09/18. The DON stated the MDS Coordinator attended morning meetings and resident discharges were discussed therefore the MDS Coordinator should have completed and transmitted Resident #2's discharge MDS assessment timely. The DON stated her expectation was that the MDS Coordinator would immediately complete a discharge MDS assessment on Resident #2 and transmit.

On 04/18/18 at 1:24 PM an interview was conducted with the Administrator who stated her expectation was that the MDS Coordinator would have completed Resident #2's discharge MDS assessment by 02/09/18. The DON stated the

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F 640	Continued From page 6 MDS Coordinator attended morning meetings and resident discharges were discussed therefore the MDS Coordinator should have completed and transmitted Resident #2's discharge MDS assessment timely. The Administrator stated her expectation was that the MDS coordinator would immediately complete a discharge MDS assessment for Resident #2 and transmit.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 1 sampled residents reviewed for hospitalization utilizing the Minimum Data Set (MDS) to reflect discharge status (Resident #70) and 1 of 1 sampled residents reviewed for dialysis utilizing the MDS to reflect dialysis treatments (Resident #15). Findings included: 1. Resident #70 was admitted to the facility on 07/26/17. A review of a physician's order dated 03/27/18 indicated Resident #70 was discharged home on 03/27/18 with home health, nursing, physical therapy and occupational therapy. A review of the physician's discharge summary indicated Resident #70 was discharged to home on 03/27/18.	F 641	1.The cause of the deficiency was a lack of system to review the assessment completion. Complete Care has a hired a MDS Corporate Nurse Consultant to create a system for accurate and timely transmissions. Resident #70 was discharged home on March 27, 2018.On January 19, 2018 the MDS Coordinator modified, corrected and submitted the discharge assessment which was accepted on April 19, 2018, for a discharge home, not to the hospital. Resident #15 currently resides at the facility. Resident #15□s quarterly assessment was modified, corrected and submitted and was accepted by the state on April 19, 2018.Resident #15□s Care Plan reflects Dialysis three days a week. 2. MDS Coordinator was educated by the Director of Nursing on the importance of transmitting data accurately and submitting assessments in an accurate	5/14/18

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F 641	Continued From page 7 A review of the Discharge/Transition Plan indicated Resident #70 was discharged on 03/27/18. A review of the discharge MDS assessment dated 03/27/18 indicated under Section A, A2100 Discharge Status that Resident #70 was not coded as discharged to the community and was coded as discharged to the hospital. On 04/19/18 at 09:58 AM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section A, A2100 Discharge Status on Resident #70's discharge MDS assessment dated 03/27/18. The MDS Coordinator stated she miscoded that Resident #70 was discharged to the hospital on 03/27/18. The MDS Coordinator stated she knew that Resident #70 had been discharge to the community on 03/27/18 and miscoded the discharge status. The MDS Coordinator stated she would need to modify the discharge MDS assessment dated 03/27/18 to reflect Resident #70 was discharged to the community on 03/27/18 and transmit the corrected discharge MDS assessment. On 04/19/18 at 10:10 AM an interview was conducted with the DON who stated her expectation was that the MDS Coordinator would have coded the discharge MDS assessment dated 03/27/18 accurately to reflect Resident #70 was discharged to the community on 03/27/18. The DON stated the MDS Coordinator attended the morning meeting and discharged residents were discussed and therefore the MDS Coordinator should have accurately coded Resident #70 was discharged to the community on 3/27/18. The DON stated her expectation was	F 641	and timely manner. MDS Corporate Nurse Consultant will be notified of discharges every Thursday by the facility MDS Coordinator. 3. Director of Nursing will review discharge assessments daily Monday through Friday during the clinical stand-up beginning on May 17, 2018. The MDS Corporate Consultant will review Assessments for accuracy and transmission in a timely manner as required by CMS, on a bi-weekly basis starting May 14th and will continue to do so, with no end date. 4. The Director of Nursing and Executive Director are responsible for implementing the Plan of Correction.	

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F 641	Continued From page 8	F 641		

that the MDS Coordinator would modify and transmit the discharge MDS assessment dated 03/27/18 to reflect Resident #70 was discharged to the community on 3/27/18.

On 04/19/18 at 10:18 AM an interview was conducted with the Administrator who stated her expectation was that the MDS Coordinator would have accurately coded the discharge MDS assessment to reflect that Resident #70 was discharged to the community on 03/27/18. The Administrator stated her expectation was that the MDS Coordinator would modify and transmit the discharge MDS assessment dated 03/27/18 to indicate Resident #70 was discharged to the community on 03/27/17.

2. Resident #15 was admitted to the facility 05/31/17 with diagnoses which included end stage renal disease requiring renal dialysis 3 days per week.

A review of a quarterly Minimum Data Set (MDS) dated 01/20/18 revealed in Section O - Special Treatments and Programs dialysis was not marked to indicate the resident was receiving dialysis.

During an interview on 04/18/18 at 10:55 AM the MDS Coordinator confirmed dialysis was not marked in Section O of Resident #15's quarterly MDS assessment dated 01/20/18. She explained she knew this resident received dialysis 3 days a week. She added she must have overlooked dialysis on this assessment and began an error correction form.

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F 641	Continued From page 9 During an interview on 04/18/18 at 2:19 PM, the Director of Nursing stated she expected MDS assessments were completed accurately.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard 2 opened NovoLog insulin FlexPens that were not dated when opened for 2 of 2 residents (Resident #67 and Resident #27) and were available for use on	F 761	1. The cause of the deficiency was the date on the old insulin pen was not legible. The old pen was discarded, and a new Insulin pen was obtained for administration for resident #67. The	5/14/18

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F 761	Continued From page 10 2 of 4 medication carts. Findings included: 1. A review of the facility policy entitled 4.1 Storage of Medications and dated 10/07 indicated (in part) medications and biologicals were to be stored properly and staff were to follow manufacturer's recommendations or those of supplier to maintain their integrity and support safe administration. Insulin was to be dated when first opened. A review of the manufacturer's instructions indicated NovoLog FlexPen insulin was to be discarded after 28 days once opened. Resident #27 was admitted to the facility on 09/21/15 with diagnoses of diabetes mellitus. A physician's order dated 02/08/18 indicated Resident #27 was to receive NovoLog insulin 5 units before meals. On 04/17/18 at 08:59 AM Resident #27's NovoLog insulin FlexPen was observed on the Front Hall medication cart ready for use and was opened and undated. On 04/17/18 at 09:02 AM an interview was conducted with Nurse #1 who stated she had not checked that Resident #27's Novolog insulin FlexPen was dated when opened prior to administering 5 units of NovoLog insulin to Resident #27 on 04/17/18 at 6:59 AM. Nurse #1 stated the facility protocol was that insulin was to be dated when opened. Nurse #1 stated she was unsure how long Resident #27's NovoLog insulin FlexPen had been opened and would expire.	F 761	Primary Care Physician and resident were notified of incident and correction. Resident #67 has been discharged from the facility on April 20, 2018. Resident #27 currently resides in the facility. The cause of the deficient practice was the date was not legible. The old pen was discarded, and a new Insulin pen was obtained for administration for resident #27. The Primary Care Physician and resident guardian were notified of incident and correction. Nurse #1 was educated by the Director of Nursing on proper labelling and storage of insulin pens. She was also informed of the proper checks during administration. 2. All licensed nurses will be in-serviced on insulin labelling, storage, and proper checking prior to administration. The Director of Nursing provided permanent markers for dating insulin pens to avoid smudging of ink pens. 3. Effective May 17, 2018, the Unit Manager will conduct Medication Cart Audits for labelling, expired medications, and accurate storage three times a week for four weeks. Then two times a week for four, then once weekly thereafter. 4. The Director of Nursing and the Executive Director are responsible for implementing this Plan of Correction	

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F 761	Continued From page 11	F 761		

A review of the Medication Administration Record (MAR) revealed Resident #27 received NovoLog insulin 5 units on 04/17/18 at 6:59 AM per Physician's orders and as indicated by Nurse #1's documentation on the MAR.

On 04/17/18 at 09:19 AM an interview was conducted with the Director of Nursing (DON) who verified Resident #27's NovoLog insulin FlexPen was opened and undated. The DON stated her expectation was that Resident #27's NovoLog insulin FlexPen would have been dated when opened per facility policy. The DON stated NovoLog insulin FlexPen was good for 28 days once opened. The DON stated because the NovoLog insulin FlexPen was not dated when opened then it could not be determined when the insulin expired. The DON stated the undated NovoLog insulin should not have been administered to Resident #27.

On 04/17/18 at 09:47 AM an interview was conducted with the Administrator who stated it was her expectation that insulin would be dated by the nurse when opened and placed on the medication cart for resident use. The Administrator stated it was her expectation that the nurse would have verified that the insulin was dated when opened as per facility protocol prior to administering insulin to Resident #27. The Administrator stated if the NovoLog insulin Flexpen was undated then the facility staff would be unable to determine when the NovoLog insulin Flexpen had expired for Resident #27.

2. A review of the facility policy entitled 4.1 Storage of Medications and dated 10/07 indicated (in part) medications and biologicals were to be

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F 761	Continued From page 12	F 761		

stored properly and staff were to follow manufacturer's recommendations or those of supplier to maintain their integrity and support safe administration. Insulin was to be dated when first opened.

A review of the manufacturer ' s instructions indicated NovoLog insulin was to be discarded after 28 days once opened.

Resident #67 was admitted to the facility on 05/18/ 15 with diagnoses of diabetes mellitus.

A physician's order dated 04/08/18 indicated Resident #67 was to receive NovoLog FlexPen 10 units before meals.

On 04/17/18 at 09:08 AM Resident #67's NovoLog FlexPen was observed on the Front Hall medication cart ready for use and was opened and undated.

On 04/17/18 at 09:10 AM an interview was conducted with Nurse #1 who stated she had not checked that Resident #67's Novolog insulin FlexPen was dated when opened prior to administering 10 units of NovoLog insulin to Resident #67 on 04/17/18 at 7:20 AM. Nurse #1 stated the facility protocol was that insulin was to be dated when opened. Nurse #1 stated she was unsure how long Resident #67's NovoLog insulin FlexPen had been opened and would expire.

A review of the Medication Administration Record (MAR) revealed Resident #67 received NovoLog insulin 10 units on 04/17/18 at 7:20 AM per Physician's orders and as indicated by Nurse #1's documentation on the MAR.

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F 761	Continued From page 13 On 04/17/18 at 09:19 AM an interview was conducted with the Director of Nursing (DON) who verified Resident #67's NovoLog insulin FlexPen was opened and undated. The DON stated her expectation was that Resident #67's NovoLog insulin FlexPen should have been dated when opened per facility policy. The DON stated NovoLog insulin FlexPen was good for 28 days once opened. The DON stated because the NovoLog insulin FlexPen was not dated when opened then it could not be determined when the insulin expired. The DON stated the undated NovoLog insulin should not have been administered to Resident #67. On 04/17/18 at 09:47 AM an interview was conducted with the Administrator who stated it was her expectation that insulin would be dated by the nurse when opened and placed on the medication cart for resident use. The Administrator stated it was her expectation that the nurse would have verified that the insulin was dated when opened as per facility protocol prior to administering insulin to Resident #67. The Administrator stated if the NovoLog insulin Flexpen was undated then the facility staff would be unable to determine when the Novolog insulin Flexpen had expired for Resident #67.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		5/17/18

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F 812	Continued From page 14 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean 1 of 1 ice machine used to provide ice for residents. The findings included: An observation of ice machine on 4/19/18 at 12:50 PM located in the nutrition room on the 200 hall revealed a pink tinged slimy substance was located on the white plastic seal under the ice machine lid. This pink substance was easily removed by the dietary manager with paper towel. An interview was conducted on 04/19/18 at 1:00 PM with Dietary Manager. The Dietary Manager stated kitchen staff wiped down the ice machine as needed. The Dietary Manager stated the ice machine needed to be consistently cleaned and the task would be assigned to a specific department. . An interview was conducted on 4/19/18 2:00 pm with the Administrator. The Administrator revealed the former Maintenance Director	F 812	1.The cause of the deficiency was that the ice machine was a task assigned to the previous Maintenance Director. After he retired, the current Maintenance Director was not aware he was to clean the ice machine. The ice machine was cleaned on April 19, 2018 by the Dietary Manager. 2. The ice machine will be cleaned on a weekly basis beginning on April 29, 2018, by the dietary department. The Dietary Manager held a meeting with the entire dietary department on April 24, 2018 and reviewed all weekly tasks, including the importance of the ice machine. The Dietary Manager created a weekly log of all cleaning responsibilities and a log specifically for the ice machine. The Dietary Manager also provided information on the procedure and the necessary cleaning materials for the ice machine. The Dietary Manager and the Assistant Dietary Manager will be responsible for cleaning the ice machine on a weekly basis.	

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F 812	Continued From page 15 recently resigned and was responsible for cleaning the ice machine. The Administrator indicated there was no current cleaning schedule for the ice machine. She stated there was a plan to contact an outside vendor to perform cleaning and maintenance on the ice machine. The administrator stated the ice machine would be cleaned weekly by the dietary department in the future.	F 812	3. Starting May 17, 2018 the Administrator will audit the ice machine for cleanliness three times a week for four weeks, then once weekly thereafter. 4. The Dietary Manager, Director of Nursing, and the Executive Director are responsible for implementing this Plan of Correction.	
F 921 SS=D	. Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to identify a chirping smoke alarm creating a safety risk 1 for 1 of 10 resident rooms (room 211). The findings included: A review of the smoke alarm user guide indicated the battery life would last for one year under normal operating conditions. The user guide revealed the alarm chirped approximately every	F 921	1. The cause of the deficiency was the Maintenance Director was not aware that the manufacturer recommendation is weekly checks of the smoke detectors. The Maintenance Director replaced the battery for the smoke detector in resident room 211 on April 18, 2018. 2. The Maintenance Director put a weekly checklist in to REQQER, which is a computer-based system for maintenance requests. This will prompt weekly checks	5/17/18

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F 921	Continued From page 16 thirty to forty seconds for a minimum of seven days. The chirping sound indicated smoke detector battery required replacement. During an observation on 4/16/18 at 8:30 AM a smoke detector alarm was chirping in resident room 211. The smoke detector was observed chirping consistently one to three minutes on 4/16/18 8:30 AM, 4/17/18 at 9:00AM, and 4/18/18 at 7:47 AM. An interview was conducted with the Nurse #2 on 04/18/18 at 08:20 AM. Nurse #2 confirmed she heard the smoke detector beeping at 8:20 AM. The Nurse #2 stated maintenance should be notified if any smoke detector alarms beeped. The Nurse #2 explained the Maintenance Director could be verbally notified or the maintenance repair could be entered in the computer log. Nurse #2 was not aware if anyone had reported the chirping smoke detector. An interview was conducted with the Maintenance Director on 04/18/18 08:28 AM. At this time, he confirmed the smoke detector in the resident room was chirping. The Maintenance Director explained the facility had separate smoke detectors in the resident rooms that required batteries. The Maintenance Director stated the smoke detector batteries were changed when staff notified him or when maintenance rounds were performed. The staff would notify him verbally or the request was entered in the computer maintenance log. The Maintenance Director was unaware of the chirping smoke detector. After this interview on 04/18/18 the Maintenance Director changed the smoke detector battery.	F 921	for the smoke detectors. The checklist form has an option for each room. The Maintenance Director will complete checks of the smoke detector batteries twice a week for four weeks, beginning on May 17, 2018. The Maintenance Director will proceed with once a week checks thereafter. The Maintenance Director will also provide information during orientation and will give a demonstration on using the computer program and the importance of notifying the Maintenance Department of smoke detector concerns. 3. The Administrator will audit the Smoke Detector logs weekly for two months, starting May 17, 2018, then every other week for four weeks, then once monthly thereafter 8. The Administrator, Maintenance Director and Director of Nursing are responsible for implementing this Plan of Correction.	

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F 921	Continued From page 17 An interview was conducted with the Administrator on 04/18/18 at 2:30 pm. The Administrator stated her expectation was for the smoke detector batteries to be replaced when the chirping started. The Administrator stated no routine smoke detector battery maintenance was scheduled. The administrator indicated staff was responsible for reporting any repairs to the maintenance department and the staff had access to enter maintenance repairs in the computer.	F 921		