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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345263 | A. BUILDING ______ B. WING ______ | C 02/22/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MACON VALLEY NURSING AND REHABILITATION CENTER** | **3195 OLD MURPHY ROAD FRANKLIN, NC 28734** |

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| E 000 | Initial Comments<br><br>An unannounced recertification and follow-up survey was conducted 02/18/19 to 02/22/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #W68Q11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>There were no deficiencies cited as a result of the complaint investigation. Event ID #W68Q11. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, | F 561 | | 3/11/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/11/2019

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

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| F 561 | Continued From page 1<br>religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident and staff interviews the facility failed to take a resident out for scheduled smoking times based on the resident's choice and care plan for 1 of 1 resident reviewed for smoking (Resident # 283).<br><br>Findings included:<br><br>Resident #283 was admitted to the facility on 03/28/2018. Diagnoses included depression, dementia, Coronary Artery Disease, hypertension, Cerebral Vascular Disease, and hemiplegia of the left lower extremity.<br><br>A review of the quarterly Minimum Data Set (MDS) dated 12/26/2018 revealed Resident #283's cognition was intact. Resident #283 was extensive assist of 1 staff member for locomotion on/off the unit. Resident #283 was coded as a current tobacco user.<br><br>Resident #283's care plan dated 1/30/19 revealed she had a problem with appropriate smoking or use of tobacco products related to decreased safety awareness. The goal was that the resident would smoke safely in a designated area with supervision. The interventions included following a smoking schedule posted on the wall in the resident's room, the nursing station, and on the door leading out to the courtyard where the designated smoking area was located. The smoking materials were locked in a secure area at the nursing station and obtained by Resident | F 561 | F561<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>Res # 23 was accompanied by a staff member out to the smoking area on 2/20/2019.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>The facility's other 2 residents that choose to smoke were accompanied to the approved smoking area by the assigned staff member.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>Revision of the Supervised smoking assignment times was completed by the Administrator to include other ancillary departments.<br><br>The Department Head Compliance Rounds monitoring tool was revised to include interview questions of supervised smokers regarding adherence to smoking times, assistance to smoking area by staff members and any concerns regarding the | |

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F 561 Continued From page 2

#283 before going out and returned to the nursing station after smoking. Resident #283 was to be assisted to the smoking area by staff, and not be left unattended. A smoking apron was to be worn by Resident #283 while smoking.

A review of the smoking assessment dated 1/30/19 revealed Resident #283 was an unsafe smoker and required direct supervision while smoking. It stated Resident #283 was alert with adequate cognitive function, good hand dexterity, good vision, and did not endanger others or self while smoking. It further revealed Resident #283 was to smoke only in the designated area and was able to extinguish a cigarette safely and completely using the ashtray provided.

An interview with Resident #283 on 02/18/2018 at 10:43 AM revealed the day shift told her they didn't have time to take her out to smoke. She stated she was assessed as being an unsafe smoker, and must be assisted and supervised when she went out to smoke. Resident #283 further reported she slept in most mornings, so she missed the 9:30 AM smoke break, but always wanted to go out for the 11:30 AM smoke break. Resident #283 revealed on 3 days of last week (she could not recall the exact days) she missed the smoke breaks on day shift because staff told her they were busy. She revealed that evening shift took her out, and always took her out to smoke.

A review of the posted smoking schedule on 02/18/2019 revealed the smoking times were 7:30 AM, 9:30 AM, 11:30 AM, 1:30 PM, 3:30 PM, 5:30 PM, 7:30 PM, and 9:30 PM. Nursing staff were to take them out to smoke. There was no time limit posted for the smoke breaks.

F 561

smoking process.

The facility staff were re-educated on Resident Rights related to the self-determination regarding Supervised Smoking process by 3/11/2019. Any staff member unable to complete training by aforementioned date will not be allowed to work their assigned shift until re-education completed.

Any new hires will receive the aforementioned education during their orientation period.

How the facility plans to monitor its performance to make sure that solutions are sustained?

The Department Head Compliance Rounds monitoring tool will be brought to the stand-down meeting 3 times a week for 4 weeks, then weekly for an additional 8 weeks.

Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.

The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.

Date of Compliance 3/11/2019.

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An interview with Nursing Assistant (NA) #1 on 02/20/2019 at 9:37 AM revealed the smoking schedule was posted in the resident's rooms and was every 2 hours. NA #1 reported he was trained on watching residents while they smoked, how to put on a smoking apron on the resident and making sure the residents put out their cigarettes appropriately. NA #1 stated when they are short-staffed they cannot take the smokers out to smoke. The interview further revealed Resident # 283 wanted to smoke multiple cigarettes when she goes out and he did not have time to spend out there when things needed to be done.

An interview with NA #2 on 02/20/2019 at 9:43 AM revealed that the residents that smoke could go during the times posted on the smoking schedule, every 2 hours.

On 02/20/2019 at 11:10 AM an observation was made of NA #1 telling Resident #283 that he could not take her out to smoke because he was busy and did not have the time.

A review of the nursing staff schedule revealed there were 3 staff scheduled for day shift on Resident #283's hall on 02/20/2019.

An interview with Resident #283 on 02/20/2019 at 12:00 PM revealed she was not taken out for the 11:30 AM smoke break because she was told they were busy and would have to wait until the next smoke break.

An interview with the Director of Nursing (DON) on 02/22/2019 at 2:44 PM stated it was her

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| F 561 | Continued From page 4<br>expectation that residents who smoked were offered and taken out to smoke at the designated break time. The DON further stated it was the resident's right.<br><br>An interview with the Administrator on 02/22/2019 at 2:45 PM revealed expectations concerning residents who smoked was they had the right to smoke and they should adhere to the resident choices regarding smoking. | F 561 | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items | F 582 | | 3/11/19 |

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| F 582 | Continued From page 5<br>and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and/or a CMS Notice of Medicare Non-Coverage (NOMNC) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Residents #1 and #29).<br><br>Findings included: | F 582 | F 582<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>Resident's #1 and #29 remain in the facility without any concerns regarding the notice of NOMNC and/or SNFABN and remain at their normal baseline of functioning. | |

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| F 582 | Continued From page 6<br>1. Resident #1 was admitted to the facility on 08/15/18.<br><br>A review of the medical record revealed a CMS-10123 NOMNC and a CMS-10055 SNF ABN were not issued to Resident #1 or their Responsible Party (RP) which indicated Medicare Part A coverage for skilled services would end on 11/22/18. Resident #1 remained in the facility.<br><br>During an interview on 02/22/19 at 12:50 PM the Administrator explained the Social Worker who had been responsible for issuing the NOMNC and SNF ABN when a resident's Medicare Part A coverage was ending was no longer employed at the facility. The Administrator was unable to locate any documentation a NOMNC and SNF ABN were provided to Resident #1 or their RP when Medicare Part A coverage ended on 11/22/18. She was unable to explain why the notices were not provided but stated going forward she would have a process in place to ensure required notices were issued prior to discharge from Medicare services.<br><br>2. Resident #29 was admitted to the facility on 09/27/18.<br><br>A review of the medical record revealed a telephone conversation was conducted on 12/12/18 with Resident #29's Responsible Party (RP) to discuss the CMS-10123 NOMNC. The discussion noted the RP was notified Medicare coverage for skilled services would end on 12/14/18 and appeal rights were reviewed. Resident #29 remained in the facility.<br><br>There was no documentation a CMS-10055 SNF ABN was provided to Resident #29 or their RP. | F 582 | How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>The Business Office manager performed a look back review of 45 days on 2/25/2019 of residents that had Medicare Part A Services that were discharged from Medicare Part A to determine if documentation of the notification is on file.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>The Business Office Manager and Social Services Director were in serviced regarding the Medicare Liability notices by the Administrator on 2/22/2019.<br><br>Effective 2/22/19 during the AM Meeting, the facility IDT team will review the NONMC and SNFABN notebook audit tool for compliance with upcoming discharges from MCR Part A coverage.<br><br>The NOMNC will be given at least 48 hours prior to end of coverage. The Social Services Director or designee will be responsible for maintaining the Log that reflects the residents that have been had a MCR Part A covered stay.<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained?<br><br>The NONMC AND SNFABN notebook audit tool will be reviewed 5 days/week | |

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| F 582 | Continued From page 7<br><br>During an interview on 02/22/19 at 12:50 PM the Administrator explained the Social Worker who had been responsible for issuing the NOMNC and SNF ABN when a resident's Medicare Part A coverage was ending was no longer employed at the facility. The Administrator was unable to locate any documentation a SNF ABN was provided to Resident #29 or their RP when Medicare Part A coverage ended on 12/14/18. She was unable to explain why the notice was not provided but stated going forward she would have a process in place to ensure required notices were issued prior to discharge from Medicare services. | F 582 | on-going during the IDT meeting for notification to beneficiaries by the Administrator.<br><br>Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.<br><br>The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.<br><br>Date of Compliance 3/11/2019. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR (Resident #57) and antipsychotic medication use for 1 of 5 residents reviewed for unnecessary medications (Resident #22).<br><br>Findings included:<br><br>1. Resident #57 admitted to the facility on 01/15/14 with multiple diagnoses that included major depression, unspecified psychosis, schizoaffective disorder, and anxiety. | F 641 | F641<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>The MDS nurse corrected and resubmitted the MDS for resident□s #22 and #57 on 2/22/2019.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>100% MDS audit was completed on | 3/11/19 |

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| F 641 | Continued From page 8<br><br>Review of the annual Minimum Data Set (MDS) dated 06/07/18 revealed Resident #57 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review was used for formulating a determination of need, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.<br><br>Review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) printout dated 02/19/19 indicated under the PASRR history detail Resident #57 had a Level II PASRR for the diagnosis type of mental illness. Further review revealed the Level II PASRR number was effective 05/12/14 with no end date listed.<br><br>During an interview on 02/21/19 at 3:20 PM, MDS Coordinator #1 confirmed she was responsible for coding Section A, Identification Information on the MDS. She reviewed the NC MUST printout dated 02/19/19 and stated she was unaware Resident #57 had a Level II PASRR. MDS Coordinator #1 acknowledged the annual MDS dated 06/07/18 was incorrectly coded and a correction would be submitted to to reflect Resident #57 was a Level II PASRR.<br><br>During an interview on 02/21/19 at 3:58 PM, the Administrator stated she expected for MDS assessments to be accurately coded.<br><br>2. Resident #22 was admitted to the facility on 07/04/18 with diagnoses that included depression among others. | F 641 | 3/01/2019 by the MDS Coordinator of all resident□s on Antipsychotics to determine correct coding on the MDS. Any errors noted were corrected and resubmitted per the RAI manual process.<br><br>100% PASRR Audit was completed by the Administrator on 3/6/2019; documentation in place accordingly in resident records and in newly created 2019 PASRR Log and Screen notebook.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>On 2/21/2019 Unit Managers, MDS Nurses, Social Services Director and AR manager received inservicing regarding the PASRR process and coding presented by the Corporate Support Team.<br>Upon admission of a resident with a Level 2 PASRR, the IDT will review the Admission MDS prior to submission in the PM IDT meeting for accuracy of coding.<br><br>Residents that have new orders for psychoactive medications will be audited using the Psychoactive Medication Audit tool during the AM IDT meeting.<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained?<br><br>The facility IDT members will utilize the Psychoactive Medication Audit tool and the PASRR Log and Screen notebook to monitor 20% of scheduled assessments | |

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| F 641 | Continued From page 9<br>Review of the most recent quarterly Minimum Data Set (MDS) dated 12/28/18 revealed Resident #22 was alert and oriented with mild cognitive impairment. The MDS also revealed Resident #22 had a diagnosis of anxiety and was taking an antianxiety, antidepressant and antipsychotic medication daily.<br><br>Review of the Medication Administration Record (MAR) for December 2018 revealed no antipsychotic medications had been given routinely or as needed throughout the month.<br><br>During an interview with the MDS Coordinator #2 on 02/22/19 at 2:53 PM, she reviewed the MAR for December of 2018 and compared it to the quarterly MDS dated 12/28/18 and stated Resident #22 had not been administered an antipsychotic medication during the month of December of 2018. MDS Coordinator #2 further stated she thought this had been unintentionally checked and she would correct the error and resubmit the MDS.<br><br>During an interview with the Director of Nursing on 02/22/19 at 5:57 PM, she stated her expectations were for the MDS to be accurately coded. | F 641 | during the PM Stand down meeting for 4 weeks, then 10% of scheduled weekly assessments for an additional 8 weeks.<br><br>Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.<br><br>The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.<br><br>Date of Compliance 3/11/2019. | |
| F 644<br>SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: | F 644 | | 3/11/19 |

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| F 644 | Continued From page 10<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to have an assessment for a Level II PASRR (Preadmission Screening and Resident Review) for 1 of 1 sampled residents (Resident #26) reviewed for Level II PASRR.<br><br>Findings included:<br><br>Resident #26 was admitted to the facility on 09/20/2016. The diagnosis included dementia without behaviors, bipolar disorder, anxiety, and depression.<br><br>A review of the last comprehensive Minimum Data Set (MDS) dated 07/13/2018 revealed that Resident #26 had been evaluated by Level II PASRR and determined to have a serious mental illness was coded with a no. The diagnosis that were coded were dementia, anxiety disorder, depression, and manic depression.<br><br>A review of a quarterly MDS dated 01/02/2019 revealed in Section I the current diagnosis of dementia, anxiety disorder, and depression. | F 644 | F644<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>On 2/21/19, Resident #26 MDS was corrected and resubmitted per the RAI manual.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>On 2/21/19 the Corporate Clinical Consultant reviewed all Level II PASRR residents including appropriate coding on the MDS and documentation on the resident□s care plan. The audit identified another resident with Level II PASRR requiring MDS correction and resubmission per the RAI manual.<br><br>100% audit of current residents was | |

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| F 644 | Continued From page 11<br>An interview with the Administrator on 02/19/2019 at 11:00 AM reported that historically the Social Worker (SW) was responsible for the Level II PASRR. She also reported that their sister facility was working on Resident #26's Level II PASRR. She stated that she had submitted a screening for the resident on 02/19/2019 since the previous Level II had expired on 10/21/2013 (ref # 1423492).<br><br>An interview with the MDS Registered Nurse #1 revealed she had been in the MDS position for 2 years and would not have known the resident had a Level II PASRR. She further revealed that she expected the SW did the Level II PASRR and since working at the facility she did not know Resident #26 was a Level II PASRR.<br><br>An interview with the interim SW revealed that usually social services was responsible for doing the evaluations for Level II PASRR. She further revealed that the previous SW was leaving the facility for another position and did not update her on which residents were a Level II PASRR. | F 644 | performed by the administrator to validate that current PASRR documentation is in place and available for review.<br><br>New residents will be reviewed prior to admission for LEVEL II PASRR coding and if they require specialized services. The Social Services Director or designee will be responsible for maintaining an accurate list of LEVEL II PASRR□s.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>On 2/21/2019 the Social Services Director was in-serviced by the corporate clinical department on the PASRR process and requirements.<br><br>On 2/21/2019 MDS nurses were re-inserviced on the coding of LEVEL II PASRR on the MDS assessments subsequent<br><br>Newly hired employees in the MDS and/or Social Services Departments will receive the aforementioned education during their facility orientation.<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained?<br><br>The Director of Nursing will review the Level II PASRR residents on a quarterly basis for accurate coding on the MDS and subsequent documentation on the plan of care. | |

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| F 644 | Continued From page 12 | F 644 | Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.<br><br>The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.<br><br>Date of Compliance 3/11/2019. | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to 1) remove two expired nutritional | F 812 | F812 | 3/11/19 |

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| F 812 | Continued From page 13<br>supplements from shelving in the walk in refrigerator, 2) reseal a bag containing individual servings of fish in the walk in freezer, 3) allow tray covers to air dry after removal from the dish machine and re-wash a dirty tray cover after removal from the dish machine and prior to storage with clean dishware and 4) clean a soiled ceiling vent in the facility kitchen.<br><br>The findings included:<br><br>1. During the initial tour of the facility kitchen on 2/18/19 from 10:30 AM-11:00 AM the following concerns were identified:<br>a. Two 8 ounce individual servings of nutritional supplement with a manufacturer's expiration date of 1/30/19 were stored on shelving in the walk in refrigerator. The Food Service Director (FSD) was present at the time of the observation and stated the two 8 ounce individual servings of expired nutritional supplement should have been removed from the walk in refrigerator. The FSD stated she expected all staff to check the walk-in refrigerator on a daily basis and remove any expired foods.<br>b. A ten pound box of individual servings of fish was observed in a bag, in a cardboard box, stored on shelving in the walk in freezer. The cardboard lid was open and the bag containing the fish was open, exposing the individual servings of fish to air. The Food Service Director (FSD) was present at the time of the observation and stated the fish should have been repackaged in a new bag to prevent exposure to air.<br><br>2. On 2/20/19 at 2:25 PM observations were made of a dietary aide working at the dish machine. The dietary aide removed a rack of tray covers from the clean side of the dish machine | F 812 | How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>The items were immediately discarded by the Certified Dietary manager on 2/18/2019.<br>On 2/22/2019 the ceiling vent was cleaned by the Maintenance Director.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>Remaining refrigerators and storage rooms were visually audited by the Certified Dietary Manager for any other expired items on 2/18/2019; items discarded accordingly.<br><br>All dietary department vents were cleaned on 2/22/2019 by the Maintenance Director.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>On 2/18/2019 the Corporate Dietary Consultant re-educated the CDM regarding discarding expired items, labeling opened items, and cleaning of equipment including vents.<br><br>On 2/28/2019 the Corporate Dietary Consultant reviewed and revised the duties of the AM and PM cooks as it pertains to the areas of storage, labeling and expiration dates. | |

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| F 812 | Continued From page 14 and wiped the moisture from tray covers with a cloth prior to placing each tray cover in clean dish storage. The first tray cover on the rack that was pulled from the dish machine was noted to have a brownish substance on the interior of the tray cover and the dietary aide wiped the substance with the cloth, placed the tray cover in clean dish storage and continued to use the cloth to wipe the moisture from the remaining tray covers. The Food Service Director came to the area of the dish machine after this observation and reported she expected staff to allow dishes coming out of the dish machine to air dry and, if dishes were soiled, to be rewashed. The dietary aide reported she was nervous and knew she should not use a cloth to wipe moisture from dishware that came out of the dish machine and knew to re-wash dishware that was soiled prior to clean dish storage.<br><br>3. On 2/21/19 from 4:30 PM-5:30 PM observations were made of staff preparing the supper meal and placing food on the steam table for supper meal service. Observations were made of the ceiling air vent positioned in the area of the steam table where food and clean dishware was stored. The individual grates of the air vent had a build-up of dust which encompassed the vent's entire surface area.<br><br>On 2/22/19 at 3:25 PM the Food Service Director (FSD) stated maintenance was responsible to clean ceiling vents and that she verbally requested maintenance clean the vent a couple weeks ago. The FSD looked at the air vent and agreed it needed to be cleaned.<br><br>On 2/22/19 at 3:40 PM the maintenance director stated he was not aware of the need to clean the | F 812 | New hires in the Dietary Department will receive the education during their orientation period.<br><br>Maintenance Director will perform weekly cleaning of the dietary vents as part of the weekly preventative maintenance schedule.<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained?<br><br>The Administrator will perform Weekly Dietary Sanitation Rounds with the Certified Dietary Manager for 4 weeks, then monthly thereafter.<br><br>Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.<br><br>The Dietary Manager and maintenance Director are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.<br><br>Date of Compliance 3/11/2019. | |

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| F 812 | Continued From page 15<br>ceiling vent in the kitchen and cleaned the kitchen ceiling vents whenever requested by the FSD. The maintenance director agreed the ceiling vent needed to be cleaned and noted the air intake vent would be prone to collect dust because of where it was positioned by the steam table. | F 812 | | |

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| {F 000} | INITIAL COMMENTS<br><br>On February 22, 2019, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the revisit and complaint investigation on 01/05/19 were corrected effective 02/04/19, the facility remains out of compliance. | {F 000} | | |
| {F 561} SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the | {F 561} | | 3/11/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/11/2019

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

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| {F 561} | Continued From page 1<br>facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident and staff interviews the facility failed to take a resident out for scheduled smoking times based on the resident's choice and care plan for 1 of 1 residents (Resident # 283) reviewed for smoking.<br><br>Findings included:<br><br>Resident #283 was admitted to the facility on 03/28/2018. Diagnoses included depression, dementia, Coronary Artery Disease, hypertension, Cerebral Vascular Disease, and hemiplegia of the left lower extremity.<br><br>A review of the quarterly Minimum Data Set (MDS) dated 12/26/2018 revealed Resident #283's cognition was intact. Resident #283 was extensive assist of 1 staff member for locomotion on/off the unit. Resident # 283 was coded as a current tobacco user.<br><br>Resident #283's care plan revealed she had a problem with appropriate smoking or use of tobacco products related to decreased safety awareness. The goal was that the resident would smoke safely in a designated area with supervision. The interventions included following a smoking schedule posted on the wall in the resident's room, the nursing station, and on the door leading out to the courtyard where the designated smoking area was located. The smoking materials were locked in a secure area at the nursing station and obtained by Resident #283 before going out and returned to the nursing station after smoking. Resident #283 was to be | {F 561} | F561<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>Res #283 was accompanied by a staff member out to the smoking area on 2/20/2019.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>The facility□s other 2 residents that choose to smoke were accompanied to the approved smoking area by the assigned staff member.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>Revision of the Supervised smoking assignment times was completed by the Administrator to include other ancillary departments.<br><br>The Department Head Compliance Rounds monitoring tool was revised to include interview questions of supervised smokers regarding adherence to smoking times, assistance to smoking area by staff members and any concerns regarding the smoking process. | |

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{F 561}

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assisted to the smoking area by staff, and not be left unattended. A smoking apron was to be worn by Resident #283 while smoking.

A review of the smoking assessment dated 1/30/19 revealed Resident #283 was an unsafe smoker and required direct supervision while smoking. It stated Resident #283 was alert with adequate cognitive function, good hand dexterity, good vision, and did not endanger others or self while smoking. It further revealed Resident #283 was to smoke only in the designated area and able to extinguish a cigarette safely and completely using the ashtray provided.

An interview with Resident #283 on 02/18/2018 at 10:43 AM revealed the day shift told her they didn't have time to take her out to smoke. She stated she was assessed as being an unsafe smoker, and must be assisted and supervised when she went out to smoke. Resident #283 further reported she slept in most mornings, so she missed the 9:30 AM smoke break, but always wanted to go out for the 11:30 AM smoke break. Resident #283 revealed on 3 days of last week (she could not recall the exact days) she missed the smoke breaks on day shift because staff told her they were busy. She revealed that evening shift took her out, and always took her out to smoke.

A review of the posted smoking schedule on 02/18/2019 revealed the smoking times were 7:30 AM, 9:30 AM, 11:30 AM, 1:30 PM, 3:30 PM, 5:30 PM, 7:30 PM, and 9:30 PM. Nursing staff were to take them out to smoke. There was no time limit posted for the smoke breaks.

An interview with Nursing Assistant (NA) #1 on

{F 561}

The facility staff were re-educated on Resident Rights related to the self-determination regarding Supervised Smoking process by 3/11/2019. Any staff member unable to complete training by aforementioned date will not be allowed to work their assigned shift until re-education completed.

Any new hires will receive the aforementioned education during their orientation period.

How the facility plans to monitor its performance to make sure that solutions are sustained?

The Department Head Compliance Rounds monitoring tool will be brought to the stand-down meeting 3 times a week for 4 weeks, then weekly for an additional 8 weeks.

Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.

The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.

Date of Compliance 3/11/2019.

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| {F 561} | Continued From page 3 | {F 561} | | |

02/20/2019 at 9:37 AM revealed the smoking schedule was posted in the resident's rooms and was every 2 hours. NA #1 reported he was trained on watching residents while they smoked, how to put on a smoking apron on the resident and making sure the residents put out their cigarettes appropriately. Also reported that when they are short-staffed we cannot take the smokers out to smoke. It was further reported by NA # 1 that Resident # 283 wants to smoke multiple cigarettes when she goes out and he did not have time to spend out there when things needed to be done.

An interview with NA #2 on 02/20/2019 at 9:43 AM revealed that the residents that smoke could go during the times posted on the smoking schedule, every 2 hours.

On 02/20/2019 at 11:10 AM an observation was made of NA #1 telling Resident #283 that he could not take her out to smoke because he was busy and did not have the time.

A review of the nursing staff schedule revealed there were 3 staff scheduled for day shift on Resident #283's hall on 02/20/2019.

An interview with Resident #283 on 02/20/2019 at 12:00 PM revealed she was not taken out for the 11:30 AM smoke break because she was told they were busy and would have to wait until the next smoke break.

A review of the revised posted smoking schedule on 02/21/2019 revealed smoking times were 8:30 AM, 11:30 AM, 2:30 PM, 4:30 PM, 7:30 PM, and 9:00 PM. It revealed that housekeeping, floor techs, medical records, and nursing staff could

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| {F 561} | Continued From page 4<br>take the residents out to smoke at the designated times.<br><br>An interview with the Director of Nursing on 02/22/2019 at 2:44 PM stated it was her expectation that residents who smoked were offered and taken out to smoke at the designated break time. Reported it was the resident's right.<br><br>An interview with the Administrator on 02/22/2019 at 2:45 PM revealed expectations concerning residents who smoked was they had the right to smoke and we should adhere to the resident choices regarding smoking. | {F 561} | | |

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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 |
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| F 000 | INITIAL COMMENTS<br><br>On February 22, 2019, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the revisit and complaint investigation on 01/05/19 were corrected effective 02/04/19, the facility remains out of compliance. | F 000 | | |
| {F 561} SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the | {F 561} | | 3/11/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/11/2019

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

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| | 345263 | A. BUILDING ______ B. WING ______ | R-C 02/22/2019 |

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| {F 561} | Continued From page 1<br>facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident and staff interviews the facility failed to take a resident out for scheduled smoking times based on the resident's choice and care plan for 1 of 1 residents (Resident # 283) reviewed for smoking.<br><br>Findings included:<br><br>Resident #283 was admitted to the facility on 03/28/2018. Diagnoses included depression, dementia, Coronary Artery Disease, hypertension, Cerebral Vascular Disease, and hemiplegia of the left lower extremity.<br><br>A review of the quarterly Minimum Data Set (MDS) dated 12/26/2018 revealed Resident #283's cognition was intact. Resident #283 was extensive assist of 1 staff member for locomotion on/off the unit. Resident # 283 was coded as a current tobacco user.<br><br>Resident #283's care plan revealed she had a problem with appropriate smoking or use of tobacco products related to decreased safety awareness. The goal was that the resident would smoke safely in a designated area with supervision. The interventions included following a smoking schedule posted on the wall in the resident's room, the nursing station, and on the door leading out to the courtyard where the designated smoking area was located. The smoking materials were locked in a secure area at the nursing station and obtained by Resident #283 before going out and returned to the nursing station after smoking. Resident #283 was to be | {F 561} | F561<br><br>How will corrective action be accomplished for those residents found to be affected by the deficient practice?<br><br>Res #283 was accompanied by a staff member out to the smoking area on 2/20/2019.<br><br>How will facility identify other residents having potential to be affected by the same deficient practice?<br><br>The facility□s other 2 residents that choose to smoke were accompanied to the approved smoking area by the assigned staff member.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?<br><br>Revision of the Supervised smoking assignment times was completed by the Administrator to include other ancillary departments.<br><br>The Department Head Compliance Rounds monitoring tool was revised to include interview questions of supervised smokers regarding adherence to smoking times, assistance to smoking area by staff members and any concerns regarding the smoking process. | |

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assisted to the smoking area by staff, and not be left unattended. A smoking apron was to be worn by Resident #283 while smoking.

A review of the smoking assessment dated 1/30/19 revealed Resident #283 was an unsafe smoker and required direct supervision while smoking. It stated Resident #283 was alert with adequate cognitive function, good hand dexterity, good vision, and did not endanger others or self while smoking. It further revealed Resident #283 was to smoke only in the designated area and able to extinguish a cigarette safely and completely using the ashtray provided.

An interview with Resident #283 on 02/18/2018 at 10:43 AM revealed the day shift told her they didn't have time to take her out to smoke. She stated she was assessed as being an unsafe smoker, and must be assisted and supervised when she went out to smoke. Resident #283 further reported she slept in most mornings, so she missed the 9:30 AM smoke break, but always wanted to go out for the 11:30 AM smoke break. Resident #283 revealed on 3 days of last week (she could not recall the exact days) she missed the smoke breaks on day shift because staff told her they were busy. She revealed that evening shift took her out, and always took her out to smoke.

A review of the posted smoking schedule on 02/18/2019 revealed the smoking times were 7:30 AM, 9:30 AM, 11:30 AM, 1:30 PM, 3:30 PM, 5:30 PM, 7:30 PM, and 9:30 PM. Nursing staff were to take them out to smoke. There was no time limit posted for the smoke breaks.

An interview with Nursing Assistant (NA) #1 on

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The facility staff were re-educated on Resident Rights related to the self-determination regarding Supervised Smoking process by 3/11/2019. Any staff member unable to complete training by aforementioned date will not be allowed to work their assigned shift until re-education completed.

Any new hires will receive the aforementioned education during their orientation period.

How the facility plans to monitor its performance to make sure that solutions are sustained?

The Department Head Compliance Rounds monitoring tool will be brought to the stand-down meeting 3 times a week for 4 weeks, then weekly for an additional 8 weeks.

Results of the audits will be presented to the QAPI meeting monthly x 3 months or until a time determined by the QAPI members for sustained compliance.

The Interdisciplinary Team Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.

Date of Compliance 3/11/2019.

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02/20/2019 at 9:37 AM revealed the smoking schedule was posted in the resident's rooms and was every 2 hours. NA #1 reported he was trained on watching residents while they smoked, how to put on a smoking apron on the resident and making sure the residents put out their cigarettes appropriately. Also reported that when they are short-staffed we cannot take the smokers out to smoke. It was further reported by NA # 1 that Resident # 283 wants to smoke multiple cigarettes when she goes out and he did not have time to spend out there when things needed to be done.

An interview with NA #2 on 02/20/2019 at 9:43 AM revealed that the residents that smoke could go during the times posted on the smoking schedule, every 2 hours.

On 02/20/2019 at 11:10 AM an observation was made of NA #1 telling Resident #283 that he could not take her out to smoke because he was busy and did not have the time.

A review of the nursing staff schedule revealed there were 3 staff scheduled for day shift on Resident #283's hall on 02/20/2019.

An interview with Resident #283 on 02/20/2019 at 12:00 PM revealed she was not taken out for the 11:30 AM smoke break because she was told they were busy and would have to wait until the next smoke break.

A review of the revised posted smoking schedule on 02/21/2019 revealed smoking times were 8:30 AM, 11:30 AM, 2:30 PM, 4:30 PM, 7:30 PM, and 9:00 PM. It revealed that housekeeping, floor techs, medical records, and nursing staff could

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| {F 561} | Continued From page 4<br>take the residents out to smoke at the designated times.<br><br>An interview with the Director of Nursing on 02/22/2019 at 2:44 PM stated it was her expectation that residents who smoked were offered and taken out to smoke at the designated break time. Reported it was the resident's right.<br><br>An interview with the Administrator on 02/22/2019 at 2:45 PM revealed expectations concerning residents who smoked was they had the right to smoke and we should adhere to the resident choices regarding smoking. | {F 561} | | |