STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM RD 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 483.25 (F323) at J Immediate Jeopardy began on 04/15/13 when Resident #104 continued to smoke on the premises and in the facility, with oxygen, and have smoking materials on her person with no interventions other than reminding her of the nonsmoking policy. The Director of Nursing Services, in the absence of the Executive Director, was informed of Immediate Jeopardy on 04/24/13 at 4:55 PM for Resident #104. Immediate Jeopardy was removed on 04/26/13 at 5:30 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D to complete education and to ensure monitoring systems put into place are effective. 483.20 (F279) at J Immediate Jeopardy began on 04/15/13 when Resident #104 continued to be non-compliant with the smoking policy and had smoking materials on her person without the development of a comprehensive care plan with measurable goals and interventions to address this behavior. The Executive Director was informed of Immediate Jeopardy on 04/25/13 at 3:27 PM for Resident #104. Immediate Jeopardy was removed on 04/26/13 at 5:30 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D to complete education and to ensure monitoring systems put into place are effective.	F 000	*Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.* *F 156* ***Criteria 1*** *Resident #12 no longer resides at the facility.* ***Criteria 2*** *Center residents receiving Medicare Benefits have the potential to be affected. An audit of 23 Medicare Denial letters since January 1, 2013 were audited by the Business Office Manager on 5/15/13 to ensure the resident and/or responsible party checked either yes or no for a Medicare Intermediary Review. Out of the 23 denial letters dispursed, 4 were due to exhaustion of 100 days of which gives the resident the option to appeal and all 4 residents and/or responsible parties checked no.*	5/30/13
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally	F 156		

DHSR NHL&C Black Mountain WRO Received MAY 29 2013 by: MMH

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

[signature] | Executive Director | 5-28-13

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.

Original signature 5-17-13 mh

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F 156	Continued From page 1 and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;	F 156	***Criteria 3*** *The Business Office Manager or designee will monitor 75% of the Medicare Denial Letters monthly to ensure that the resident and/or responsible party checks yes or no for a Medicare Intermediary Review if applicable starting 5/15/13. Instructions will be provided to residents and/or responsible party as needed. The BOM will ensure there is a specified rationale for stating why Medicare Services are no longer covered and the option to appeal if applicable is given. The ED is responsible for overall monitoring of the system.* ***Criteria 4*** *The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting for three months or until deemed compliant by QAPI committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.*	

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F 156	Continued From page 2 A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	*F 159* ***Criteria 1*** *Written instructions given to residents and/or responsible parties on admission now reflect, "During off hours, holidays, and weekends petty cash is available, please see any charge nurse or manager on duty to assist you." Residents #6, #48, and #36 were interviewed and funds provided as requested. Written instructions were provided on how to obtain their funds during off-hours, holidays, and weekends.* ***Criteria 2*** *Center residents who have facility manage funds and are deposited into Resident Trust Accounts have the potential to be affected. The facility will notify the residents in writing on/or before May 17, 2013 that petty cash is available during off hours, holidays, and weekends for those residents with monies in resident trust accounts.* ***Criteria 3*** *The Director of Activities or designee will monitor resident's knowledge of this process through resident council meetings monthly. Instructions will be provided to residents as needed. A monthly audit for three months and then quarterly thereafter for all center residents that are alert and oriented and deposit their funds to the facility will be completed to ensure residents receive their funds as desired. Audit will be completed by the Director of Social Services. All charge nurses and Mangers on Duty were educated for the actions to take if a resident request money during the off hours on 5/15/13. The ED will be responsible for monitoring the system.*	5/30/13

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a detailed explanation as to the reason Medicare coverage was ending and failed to determine if a resident wanted to request a Medicare Review for 1 of 2 sampled residents' Medicare Non-coverage letters. (Resident #12). The findings are: Resident #12's notification of Medicare non-coverage was mailed to the responsible party on 10/08/12. a. The notice "SNF (Skilled Nursing Facility) Determination on Continued Stay" stated that Resident #12's medical information was reviewed and found that the services furnished no longer qualified as covered under Medicare beginning 10/11/12. The letter continued: "The reason is: Services do not require daily skilled nursing or rehabilitation services." Interview on 04/25/13 at 10:33 AM with the Minimum Data Set (MDS) Coordinator, who was responsible for sending the notification letters, stated that she used this form, which was a corporate form with the reason already included on the form. She stated she did not give a more detailed explanation of the reason skilled services would no longer be paid for by Medicare. Resident #12 became a Medicaid recipient for 10 days before going under the care of Hospice. b. Review of the SNF (skilled nursing facility)	F 156	***Criteria 4*** *The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting for three months or until deemed compliant by QAPI committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.* *F 242* ***Criteria 1*** *On 4/26/13 Resident #48 was accessed by therapy and deemed unsafe for baths. This information was explained to Resident #48.* ***Criteria 2*** *A 100% audit of all facility residents was conducted by the Director of Social Services on 5/15/13 in regards to resident choice of shower or bath and Resident #48 stated he would rather have a shower. Once tubs are in, anyone who prefers a tub bath will be given one.*	5/30/13

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F 156	Continued From page 4 Determination on Continued Stay letter revealed the responsible party did not check either the yes or no option as to whether she wanted a request for a Medicare Intermediary Review. Interview with the Business Office Manager (BOM) on 04/25/13 at 10:30 AM revealed that the MDS Coordinator completed the letters and the BOM sent the letters and filed the returned letters/responses. The BOM stated she did not see that an option for review had not been checked on Resident #12's returned response.	F 156	***Criteria 3*** *During the 72-hour meeting following admission, residents will be asked for their preference of shower or bath by the Director of Social Services or designee starting 5/15/13 and resident choices will be monitored by the Director of Activities or designee in the monthly resident council meeting. 100% audit of alert and oriented resident residing in the facility in reference to their choice of tub bath or shower will be completed monthly for three months and quarterly thereafter by the Director of Social Services for periodic preference monitoring. The ED will be responsible for monitoring the system.* ***Criteria 4*** *The auditing tools from resident council, facility audit and 72-hour meeting notes will be brought to monthly QAPI meeting for three months or until deemed compliant by QAPI Committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.*	
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's	F 159		

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F 159	Continued From page 5 behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to make available resident fund account money on the weekends for 3 of 4 sampled residents. (Residents #6, #48 and #36). The findings included: 1. Resident #6 stated on 04/23/13 at 1:57 PM that she cannot get money out of her personal fund account managed by the facility on the weekends as the office staff were not in the building. Interview with the Business Office Manager (BOM) on 04/25/13 at 11:05 AM revealed the	F 159	*F 253* ***Criteria 1*** *All areas were cleaned immediately so the residents would remain in a clean, comfortable and homelike environment.* ***Criteria 2*** *A facility wide audit was conducted to ensure cleanliness by the Director of Environmental Services and Regional Director of Environmental Services for HealthCare Services Group, INC on 4/29/13.* ***Criteria 3*** *100% of housekeeping staff were educated on the proper cleaning techniques for resident areas "Complete Room Cleaning" provided by Director of Environmental Services on 4/25/13. Daily Zone Checklist for resident rooms are completed by management staff to ensure cleanliness. ED will complete monthly checklist provided by HealthCare Service Group, INC. The ED will be responsible for monitoring the system.*	5/30/13

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F 159	Continued From page 6 business office was opened Monday through Friday 8 AM to 5 PM. Once a month to once every 6 weeks she worked as Manager on Duty on the weekend. The BOM stated that there was no system to have money available for residents on the weekends. She stated she went around to the residents on Fridays to ask them if they needed any money from their accounts for the weekend. If the residents wanted money for the weekend, she gave them money on Fridays. She further stated she did not feel safe leaving petty cash in the nurses medication cart for weekend use. She said that staff could call her and she would come in to get money for a resident in an emergency. This had only occurred once in the last 12 years. She also stated she was unaware any resident had concerns about their money not being available on the weekends. On 04/25/13 at 12:20 PM, Resident #6 stated she would like to get her money anytime, including the weekends, but in the past she had been told she could not get money on the weekends. On 04/25/13 at 4:47 PM, the Executive Director (ED) stated that on the weekends there was a manager on duty and if a resident needed money from their account the manager or any nurse could call the ED, Director of Nursing Services (DNS) or the BOM who would come to the facility to get their money to them. The DNS, present at this interview, stated if a resident asked on Saturday or Sunday if the business office was open, staff would answer no. If they asked for money out of their account, then nursing staff could call one of the managers to request them to come to the facility and give the resident money from his/her account. The ED further stated that	F 159	*Criteria 4* *The auditing tools will be brought to monthly QAPI meeting for three months or until deemed compliant by QAPI Committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of* *Social Services, and Director of Rehabilitation Services.* *F 279* *Criteria 1* *Resident #104 discharged from the facility on 4/30/13. Prior to discharge on 4/24/13 resident was placed 1:1 continuous direct staff supervision care. Smoking care plan developed for Resident #104 on 4/4/13.*	5/30/13

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F 159	Continued From page 7 staff go around on Friday and ask the residents if they need money for the weekend as the residents were in the habit of getting their weekend money on Fridays. 2. Resident #48 stated on 04/22/13 at 5:04 PM that he cannot get money out of his personal fund account managed by the facility on the weekends because the office was not opened on Saturdays or Sundays. Interview with the Business Office Manager (BOM) on 04/25/13 at 11:05 AM revealed the business office was opened Monday through Friday 8 AM to 5 PM. Once a month to once every 6 weeks she worked as Manager on Duty on the weekend. The BOM stated that there was no system to have money available for residents on the weekends. She stated she went around to the residents on Fridays to ask them if they needed any money from their accounts for the weekend. If the residents wanted money for the weekend, she gave them money on Fridays. She further stated she did not feel safe leaving petty cash in the nurses medication cart for weekend use. She said that staff could call her and she would come in to get money for a resident in an emergency. This had only occurred once in the last 12 years. She also stated she was unaware any resident had concerns about their money not being available on the weekends. On 04/25/13 at 4:47 PM the Executive Director (ED) stated that on the weekends there was a manager on duty and if a resident needed money from their account the manager or any nurse could call the ED, Director of Nursing Services (DNS) or the BOM who would come to the facility	F 159	*Criteria 2* *On 4/25/13 the Interdisciplinary Team including ED, Director of Nursing Services, Assistant Director of Nursing, Director of Social Services, Director of Clinical Education, Director of Dining Services, MDS Coordinator were educated by the Reimbursement Consultant about updating care plans for residents who are non-compliant with the smoking policy to include interventions as follow: offer substitutions for smoking such as nicotine patches, electronic cigarettes, search resident room and belongings for smoking materials, and staff will report immediately to supervisor/charge nurse any breach of the smoking policy. This was specifically for Resident #104 and applies to all facility residents. The specific interventions were added to Care Plan with non-compliance of Smoking Policy as of 4/25/13. On 4/24/13 all facility residents were reassessed regarding smoking history or a potential risk for smoking in the future by the Nursing Services Consultant and the Care Plans were audited and updated to include the interventions as follow: 1:1 continuous direct staff supervision for 72 hours, then re-evaluate for those residents found in breach of the smoking policy, educated regarding smoking policy and hazards of non-compliance of Smoking Policy, and all 6 "grand fathered in" residents were re-educated regarding the smoking policy on 4/24/13 by the Director of Social Services. The Director of Social Services mailed a letter to all of the responsible parties on 4/26/13 regarding the smoking policy, residents not allowed to have smoking materials in their possession and that if out of the facility, will be required to relinquish	

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F 159	Continued From page 8 to get their money to them. The DNS, present at this interview, stated if a resident asked on Saturday or Sunday if the business office was open, staff would answer no. If they asked to get money out of their account, then nursing staff could call one of the managers to request them to come to the facility and give the resident money from his/her account. The ED further stated that staff go around on Friday and ask the residents if they need money for the weekend as the residents were in the habit of getting their weekend money on Fridays. 3. Resident #36 stated on 04/23/13 at 9:09 AM that she could get money from the business office from her account during the week but not on Saturday or Sundays. Interview with the Business Office Manager (BOM) on 04/25/13 at 11:05 AM revealed the business office was opened Monday through Friday 8 AM to 5 PM. Once a month to once every 6 weeks she worked as Manager on Duty on the weekend. The BOM stated that there was no system to have money available for residents on the weekends. She stated she went around to the residents on Fridays to ask them if they needed any money from their accounts for the weekend. If the residents wanted money for the weekend, she gave them money on Fridays. She further stated she did not feel safe leaving petty cash in the nurses medication cart for weekend use. She said that staff could call her and she would come in to get money for a resident in an emergency. This had only occurred once in the last 12 years. She also stated she was unaware any resident had concerns about their money not being available on the weekends.	F 159	*smoking materials to facility staff upon return to the facility. This letter will also be delivered on admission starting 4/26/13. Family members will be re-educated at the next scheduled Family Night on May 29, 2013.*	

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F 159	Continued From page 9 On 04/25/13 at 4:47 PM the Executive Director (ED) stated that on the weekends there was a manager on duty and if a resident needed money from their account the manager or any nurse could call the ED, Director of Nursing Services (DNS) or the BOM who would come to the facility to get their money to them. The DNS, present at this interview, stated if a resident asked on Saturday or Sunday if the business office was open, staff would answer no. If they asked if they could get money out of their account, then nursing staff could call one of the managers to request them to come to the facility and give the resident money from his/her account. The ED further stated that staff go around on Friday and ask the residents if they need money for the weekend as the residents were in the habit of getting their weekend money on Fridays.	F 159	*Criteria 3* *Starting 4/26/13 all newly admitted residents will be reviewed by the Nursing and Social Services Interdisciplinary Team during the next daily Clinical Start-Up meeting after admission to discuss smoking history and determine potential future smoking risks and ensure Care Plan interventions address risk of non-compliance with Smoking Policy for residents deemed high risk . Until 5/24/13, the Director of Nursing Services or designee will review each new resident's Smoking Assessment to determine appropriate level of risk and appropriate Care Plan interventions based upon resident's history of tobacco use. After 5/24/13 the Director of Nursing Services or designee will review 50 percent or more newly admitted resident 's Smoking Assessment to determine appropriate level of risk and appropriate Care Plan interventions based upon resident 's history of tobacco use. This will occur for three months. The Executive Director will review 10% or more of new resident Care Plans to ensure appropriate interventions are in place according to Smoking Policy and resident 's history of tobacco use. This will occur for three months. 100% of facility employees completed a competency validation test on or before 4/29/13 of which included the procedures for smoke breaks, location of items kept between smoke breaks, the meaning of resident supervision, procedure for residents found smoking without supervision, and procedure for residents who have smoking materials in their room. The ED will be responsible for monitoring the systems.*	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and record review, the facility failed to honor the choice for a bath versus a shower for 1 of 3 sampled residents. (Resident #48).	F 242		

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	345010	A. BUILDING _____ B. WING _____	04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM RD ASHEVILLE, NC 28804

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F 242	Continued From page 10 The findings included: Resident #48 was admitted on 03/30/12. The annual Minimum Data Set (MDS) dated 04/08/13 coded Resident #48 as having no cognitive deficits, no behaviors, and requiring extensive assistance with hygiene and total dependence for bathing. He was coded as having upper and lower impairment of extremities on both sides related to range of motion. The Care Area Assessment related to activities of daily living skills dated 04/08/13 stated he was dependent on staff. The care plan related to self care impairment, last updated 04/04/13, included interventions to anticipate and meet his needs and to encourage choices with care. Observations made on 04/22/13 at 3:01 PM during initial tour of the facility revealed the common shower room on the 200 hall had no bath tub and the 100 hall common shower room had a whirlpool tub but it was soiled with reddish rust under the seat. On 04/22/13 at 4:48 PM, Resident #48 stated during interview that he would prefer a bath to a shower, however, there was no bath tub in this facility. He further stated that if he were home, he would take a bath. On 04/25/13 at 2:56 PM, Resident #48 again stated he would like a bath but "they don't have one." When asked if he told someone he would prefer a bath, he stated "lady it doesn't matter, they ain't got one."	F 242	***Criteria 4*** *The ED will present all results associated with changes to residents' care plans, and any changes thereof, to the QAPI Committee for three months and then quarterly beginning August 2013 and ending in December 2013. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.* *F 312* ***Criteria 1*** *Resident #48 had their nails trimmed and cleaned on 4/29/13 by the Assistant Director of Nursing.* *Resident # 16 had their nails trimmed and cleaned on 4/29/13 by the Assistant Director of Nursing.* ***Criteria 2*** *A 100% audit of all facility residents was conducted by the Assistant Director of Nursing, Director of Clinical Education, and Unit Manager on 4/29/13 to ensure all residents had nails cleaned, trimmed, and free of jagged edges.*	5/30/13

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F 242	Continued From page 11 On 04/25/13 at 6:00 PM, the Maintenance Director stated that the 200 hall tub had not been used since 2004, the residents didn't like it, it got dirty and he was told to remove it. He further stated that the 100 hall tub had not worked to his knowledge in 13 years. He stated there were some tubs available for use in some of the private rooms. On 04/25/13 at 6:02 PM, the Social Worker stated when someone was admitted to the facility they were not asked about their preferences between a bath or a shower. She stated if they have a preference and tell her, she would arrange it. She was unaware of anyone requesting a bath, including Resident #48. During further interview on 04/25/13 at 6:33 PM, the Social Worker stated at the 72 hour meeting after admission, the facility met with residents and families and had a discussion of preferences with bathing. She had no documentation of this discussion. She stated they would use the 100 hall shower room tub. This preference would not be discussed again unless the resident brought a new preference to their attention and then it would be added to the care plan meeting notes. Interview with the Director of Nursing Services on 04/25/13 at 6:50 PM revealed she was unsure if the 100 hall shower room tub worked anymore. She further stated occupational therapy would have to evaluate Resident #48 to see if he could be placed in a tub.	F 242	*Criteria 3* *An in-service was conducted by the Director of Clinical Education on 5/7/13 for all licensed nurses and certified nursing assistants in regards to activities of daily living with special emphasis on residents' grooming with regards to nail care. The ED will be responsible for monitoring the system.* *Criteria 4* *Audits will be conducted by the Assistant Director of Nursing, Director of Clinical Education, and Unit Manager for 75% of facility residents to ensure that nails are trimmed. The audit will be conducted two times per week ongoing. The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.*	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 12 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to keep a shower room in good repair and shower rooms and bathrooms clean for 2 of 2 shower rooms and 5 of 24 bathrooms observed (Room 202 bathroom, bathroom between rooms 214 and 215, Room 218 bathroom, Room 100 bathroom, and Room 217 bathroom). The findings included: 1. On 04/22/13 at 3:05 PM during a tour of the facility, in the bathroom of room 202, brown debris was observed on the seat extender on the commode. An observation on 04/24/13 at 5:55 PM of the bathroom in room 202 revealed brown stain behind commode and on the seat extender of commode. On 04/26/13 at 2:09 PM a tour of the facility was conducted with the Housekeeping Manager. The brown stains were observed behind the commode and on the seat extender of the commode in the bathroom of 202. 2. On 04/22/13 at 3:08 PM a tour of the facility was conducted. In the bathroom used by residents in room 214 and 215, there was an unlabeled bedpan on floor by commode with urine residue inside. There were five urine hats	F 253	*F318* ***Criteria 1*** *Resident #48's Cardex was corrected to state "right" arm brace and to apply for 6 hours on day shift. All licensed nurses and certified nursing assistants were educated by the Director of Clinical Education on the application and time frame of resident #48's splint on 5/7/13.* ***Criteria 2*** *A 100% audit of all facility residents with current physician orders for splints was conducted on 4/29/13 by the MDS Coordinator to ensure physician order correctly matches Cardex instruction, proper application of splint, and actual application of splint had taken place.* ***Criteria 3*** *An in-service was conducted by the Director of Clinical Education and Therapy Staff on 5/7/13 for all licensed nurses and Certified Nursing Assistants on proper application of splints for residents currently wearing splints. The ED will be responsible for monitoring the system.*	5/30/13

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F 253	Continued From page 13 piled on floor with bags of linen and other bagged items. Black debris was observed built up in corners of bathroom and stains and debris was observed on the seat extender of the commode. An observation on 04/23/13 at 2:00 PM, in bathroom shared by residents in rooms 214 and 215 revealed yellow and brown residue in a bedpan on floor and five urine hats stacked in shower. There were brown stains and debris in corners of floor around commode and shower, and stains and debris on seat extender of commode. An observation on 04/24/13 at 5:45 PM of the bathroom shared by residents of rooms 214 and 215 revealed soiled urine hats on floor of the shower, trash on floor, and brown residue inside the bottom of the commode seat extender. Interview was conducted with Resident #6, who used the bathroom between rooms 214 and 215, on 04/24/13 at 5:50 PM. Resident #6 reported she felt afraid to use the bathroom adjoining her bedroom because it was always dirty and unsanitary. On 04/26/13 at 2:09 PM a tour of the facility was conducted with the Housekeeping Manager. In the bathroom used by residents in rooms 214 and 215, unlabeled bedpan with urine residue inside was observed on the floor by the commode. Five urine hats piled on floor were observed with bags of linen and other bagged items. Also observed was black debris built up in the corners of bathroom, and stains and debris on the commode seat extender.	F 253	*Criteria 4* *Splint audits of 100% of facility residents wearing splints will continue to be conducted ongoing once a week for one month and quarterly thereafter by the MDS Coordinator to ensure proper care is matches the physician orders and is provided. As new physician orders are obtained, the resident will be placed on the auditing tool. A splint notebook was created by the Director of Clinical Education, which will help with monitoring the splints as well as provide staff will accurate application techniques for all residents wearing splints. The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.*	

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F 253	Continued From page 14 3. On 04/22/13 at 3:12 PM an observation of the bathroom of room 218 revealed an unlabeled urinal with yellow residue. There were several wipes with brown smears on them observed on the back of the commode seat. An observation was conducted on 04/25/13 at 2:50 PM of bathroom used by residents living in room 218. There were brown residue and clumps on the commode seat and on the wall next to commode. Also observed were brown smears on floor in front of the commode. On 04/26/13 at 2:09 PM a tour of the facility was conducted with the Housekeeping Manager. In the bathroom used by residents in room 218, brown stains and debris was observed in and around the commode seat and floor. 4. On 04/22/13 at 3:16 PM a tour of the facility was conducted. In the bathroom of room 100, brown debris was observed in and around the seat extender of the commode. Dirt around base of commode, dirty hand rails, and dirt and fuzz in drain of bathtub were observed. An observation on 04/25/13 at 5:27 PM of the bathroom in room 100 was conducted. Dirt and fuzzy debris was observed in the bathtub drain. Brown stains and debris was observed on the seat extender of the commode. On 04/26/13 at 2:09 PM a tour of the facility was conducted with the Housekeeping Manager. In the bathroom of room 100 was observed chunks of debris and fuzz in and around drain of bathtub, and dirt around base of the commode and on the seat extender of commode.	F 253	*F 323* ***Criteria 1*** *Resident #104 discharged from the facility on 4/30/13. Prior to discharge on 4/24/13 resident was placed 1:1 continuous direct staff supervision care. Smoke alarm added to Resident #104's bathroom on 4/21/13.* ***Criteria 2*** *A smoking safety assessment was completed on the 6 "grand fathered in" residents on 4/24/13 by the Nursing Services Consultant. All residents were reassessed for smoking and on 4/24/13 by the Nursing Services Consultant. All smoking residents were educated on the smoking policy by the Director of Social Services on 4/24/13. All residents and/or responsible parties were mailed a letter with regards to facility being non-smoking and the protocol to for residents to relinquish all smoking material when returning back to the facility on 4/25/13. All residents and/or responsible parties will receive the smoking policy on or before admission by the Director of Admissions or designee. All newly admitted residents will be reviewed by the Nursing and Social Services Interdisciplinary Team during the next daily meeting after admission or before to discuss smoking history and determine potential future smoking risks starting 4/26/13.*	

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F 253	Continued From page 15 5. On 04/22/13 at 3:19 PM an observation of the bathroom used by residents in room 217 was conducted. A soiled seat extender, dirt around base of commode, and dirt and brown debris was observed on floor around commode. Paper debris including an opened medication patch with the date of 03/07/13 written on it was observed on the bathroom floor. An observation on 04/25/13 at 12:55 PM of the bathroom in room 217 revealed brown stains on the seat extender of the commode and stains and debris on floor around commode. An opened paper wrapper of a packaged ointment was observed on floor behind commode. An observation on 04/23/13 at 10:38 AM, in bathroom used by residents in room 217 revealed stains and debris on the seat extender of the commode. Brown dirt and debris was observed on floor around commode. An open medication patch with the date of 03/07/13 written on it was observed on the bathroom floor. An observation on 04/25/13 at 3:15 PM of bathroom in room 217 revealed an opened paper wrapper of a packaged ointment was on the floor behind commode. On 04/26/13 at 2:09 PM during a tour of the facility was conducted with the Housekeeping Manager. In the bathroom used by residents in room 217, stains inside and around the seat extender of the commode, dirt around base of commode, and dirt and brown debris on floor around the commode were observed. The opened paper wrapper of a packaged ointment	F 253	*Criteria 3* *Starting 4/26/13 all newly admitted residents will be reviewed by the Nursing and Social Services Interdisciplinary Team during the next daily Clinical Start-Up meeting after admission to discuss smoking history and determine potential future smoking risks and ensure Care Plan interventions address risk of non-compliance with Smoking Policy for residents deemed high risk . Until 5/24/13, the Director of Nursing Services will review each new resident's Smoking Assessment to determine appropriate level of risk and appropriate Care Plan interventions based upon resident's history of tobacco use. Until 5/24/13 the Executive Director will review 10% of new resident Care Plans to ensure appropriate interventions are in place according to Smoking Policy and resident's history of tobacco use. 100% of facility employees completed a competency validation test on or before 4/29/13 of which included the procedures for smoke breaks, location of items kept between smoke breaks, the meaning of resident supervision, procedure for residents found smoking without supervision, and procedure for residents who have smoking materials in their room. For residents with a history of smoking, searches for smoking materials will be completed upon entrance into the facility. Weekly room audits or as deemed necessary for smoking materials will be completed for residents with a history of smoking. This will be completed by the assigned manager or designee and documented on the daily zone checklist form. The ED will be responsible for monitoring the systems.*	

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F 253	Continued From page 16 was observed on the floor behind commode. 6. On 04/22/13 at 3:22 PM an observation was conducted of the shower room used by residents on the 100 hall. Black debris was observed under the tub chair, stains and debris were observed on the floor, and hand sanitizer was observed spilled on wall around hand sanitizer dispenser. Trash that included wads of green string, plastic cups, and paper towels was observed on the floor. An observation was conducted on 04/25/13 at 3:00 PM of the shower room used by the residents on the 100 hall. Black debris under tub chair in bathtub and hand sanitizer streaks on wall next to hand sanitizer dispenser was observed. The floor was observed soiled with trash and stains including wads of green string, plastic cups and paper towels. On 04/26/13 at 2:09 PM during a tour of the facility with the Housekeeping Manager the 100 hall shower room was observed unchanged from the previous observation on 04/25/13. 7. On 04/22/13 at 3:30 PM an observation of the shower room used by the residents on the 200 hall was conducted. Mold was observed around the base of the shower walls and floor. Broken and jagged tiles were observed on the wall by the first shower. An observation on 04/24/13 at 5:32 PM of shower room used by residents on 200 hall revealed the mold and tiles remained unchanged. Brown swipes were also observed on a large shower curtain.	F 253	*Criteria 4* *The results of these audits will be brought to the monthly Quality Assurance Performance Improvement meeting for three months or until deemed compliant by QAPI committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.* *F 371* *Criteria 1* *No resident was named in this deficiency. No residents experienced negative outcomes. On 4/24/13 all items not labeled or dated were discarded out of both 100 and 200 hall nourishment room refrigerators. All other items located in the refrigerators were in compliance. On 4/26/13 the microwaves in both 100 and 200 hall nourishment rooms were cleaned. The ice scoop container with rusty screws was replaced immediately. On 5/15/13 Maintenance contacted pest control for a visit to establish parameters for fly control.*	5/30/13

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F 253	Continued From page 17 On 04/26/13 at 2:09 PM an observation of the 200 hall shower room was conducted with the Housekeeping Manager. The mold around the base of the shower walls and floor and the brown smears on the large shower curtain remained unchanged. Interview with Housekeeping Manager on 04/26/13 at 2:09 PM revealed he ordinarily monitored the bathrooms and shower rooms daily. He stated his supervisor also checked the cleanliness of the bathrooms and shower rooms each week. He stated that currently, due to one housekeeper being in the hospital, he was working on the floors and wasn't able to monitor the cleanliness of the bathrooms and shower rooms.	F 253	***Criteria 2*** *Center residents have the potential to be affected. Corrective action accomplished for those residents having potential to be affected by the same practice.* ***Criteria 3*** *Dietary and Nursing staff were educated on 5/7/13 proper techniques for food procurement, storing, labeling, and serving in sanitary conditions with emphasis on storing and labeling. Housekeeping staff was educated on cleanliness of microwave and the proper ways to keep the microwaves clean along with the sinks, refrigerators, freezers, and ice machines in nourishment rooms. Nursing staff was educated on 4/29/13 cleanliness of ice buckets and apparatus along with the proper storage techniques and usage during the passing of ice. Ice cooler/scoops will be cleaned daily by the dietary department. Nursing will deliver each ice cart to the dietatry department daily. Dietary will return the clean carts to nursing. A daily sign-off sheet will be kept to record completion of this task. Dietary will be responsible for checking the food in the nourishment room. Dietary will check that all food is labeled, dated, and covered to maintain safety of the food and the residents. Dietary aides/cooks will check rooms twice a day, DDS will check twice a day. ED will be responsible for overall monitoring of systems.*	
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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F 279	Continued From page 18 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and resident interviews, the facility failed to develop a comprehensive care plan with individual goals and interventions which addressed 1 of 7 sampled residents for smoking safety. (Resident #104). Immediate Jeopardy began on 04/15/13 when the facility did not develop a plan of care which addressed Resident #104's smoking with oxygen and failure to follow the facility's smoking policy. The goal was not specific to Resident #104's noncompliance with the smoking policy and the interventions were not specific as to Resident #104's repeated possession of smoking materials, smoking in non-smoking areas on the non-smoking premises, and smoking with oxygen in use. Immediate jeopardy was removed on 04/26/13 at 5:30 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. The findings included: The facility provided evidence in the form of a	F 279	***Criteria 4*** *These audits will be ongoing for continuous compliance and safety for residents. The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting for three months or until no longer deemed necessary by the QAPI Committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.* *F 441* ***Criteria 1*** *There were no negative outcomes for resident #48. All nursing staff were educated to wear gloves when touching resident's food as evidenced with resident #48. All staff were educated on hand hygiene during tray passes as evidenced with residents #48 and #37. Education was provided by the Director of Clinical Education on 4/29/13.* ***Criteria 2*** *All residents had potential to affected by deficient practice. All staff were educated on hand hygiene during meal passes by the Director of Clinical Education on 4/29/13.*	5/30/13

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F 279	Continued From page 19 letter dated 10/30/12 "To Whom It May Concern" which informed the reader that on 11/01/12 the facility became a smoke free building. The policy was effective for all residents, families and visitors. The policy stated new residents admitted to the facility must adhere to the policy on admission. The policy stated "Smoking is prohibited on the grounds of Golden Living Center including outside building entrances, courtyards, parking lots and inside building. 'No Smoking' signs will be posted in the restricted areas." The facility's smoking policy last reviewed and revised April 2013 stated that "While Golden Living Center-Asheville will continue to allow residents who chose to smoke tobacco products the privilege of smoking in approved areas and at approved times. Smoking will only be allowed as outlined in this policy and will be monitored for compliance and enforced. This policy will be distributed upon admission to each resident and their responsible party." The guidelines included: *All material related to smoking will be stored at the nursing stations; *Each resident smoker will be assessed for their own individual abilities and circumstances and care planned for this ability; *Smoking is not permitted inside the building. The designated area for smoking is located in the facility courtyard; *Oxygen use is prohibited in smoking areas; *Smoking times are established and smoking is permitted only in the designated area and during acceptable weather; *Any resident, visitor or associate who does not comply with the facility rules regarding smoking	F 279	***Criteria 3*** *The Director of Nursing Services, Assistant Director of Nursing and Director of Clinical Education will audit hand hygiene for 3 or more CNAs and 3 or more residents during meal passes three times per week for three months and quarterly thereafter. The ED is responsible for monitoring the system.* ***Criteria 4*** *These audits will be completed as referenced in Criteria 3 above for continuous compliance and safety for residents. The results of this audit will be brought to the monthly Quality Assurance Performance Improvement meeting for three months or until no longer deemed necessary by the QAPI Committee. Any trends or issues will be addressed by the QAPI committee for continued compliance. The Quality Assurance Performance Improvement Committee consists of Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Clinical Education, Unit Manager, Director of Dining Services, Maintenance Director, Director of Medical Records and Central Supply, Director of Activities, Director of Social Services, and Director of Rehabilitation Services.*	

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may be asked to forfeit smoking or visiting privileges. If the danger of lack of compliance is serious enough, it may warrant discharge in accordance with state and federal law.

Resident #104 was admitted to the facility on 03/05/13 with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, hypertension, tobacco use, depression, anxiety and bipolar disease. Physician orders since admission included continuous oxygen at 4 liters per minute. Resident #104 signed the "Acknowledgement of No Smoking Policy" on 03/05/13 which stated the resident had been informed that the current law was that residents sign acknowledgement that smoking was prohibited inside all long term care facilities.

The admission Minimum Data Set for Resident #104, dated 03/12/13 coded her moderately impaired in decision making skills, feeling down, requiring limited assistance for bed mobility, transfers, walking in room, hygiene and toileting. She was coded as being unsteady and needed assistance to stabilize her balance. There was no smoking assessment and no care plan specific to smoking.

The resident's desire and attempts to smoke were revealed as follows:
*Nursing notes dated 03/13/12 at 3:44 PM revealed Resident #104 "requested to smoke today, explained the facility smoking policy."
*Nursing notes dated 03/15/13 at 12:05 AM stated that the nurse took a cigarette lighter from Resident #104. The resident was noted to be going up and down the hall, rolled to back door

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and stated she wanted to go outside to smoke. Per the nursing note, the nurse explained the resident was using oxygen and was unable to be around open flames.
*On 04/04/13 at 3:58 PM, a social service note stated the social worker (SW) met with Resident #104 regarding the smoking policy due to resident inquiring about smoking on campus. An interview with the SW on 04/24/13 at 10:55 AM revealed that on 04/04/13 it was brought to the SW's attention that Resident #104 was caught smoking out the back door in the parking area the weekend before (March 30-31st). The SW stated either a nurse aide or a manager on duty (she could not recall specifically who) informed her on 04/04/13 about the previous weekend event so she spoke to Resident #104 about the smoking policy and possible discharge from the facility for noncompliance. Resident #104 voiced understanding. The SW stated on 04/25/13 at 3:17 PM that she originally developed a care plan on 04/04/13 relating to Resident #104's smoking.

The focus of the care plan initiated 04/04/13 was the resident was "At risk for smoking related injury related to history of smoking incidents." The goal was "will have no smoking related injuries." The only intervention was "Review smoking policy with patient and or family."

Additional evidence of Resident #104's non-compliance with smoking included:
*Social Service Note dated 04/15/13 at 3:15 PM revealed that the housekeeping staff informed the SW that Resident #104 was attempting to smoke outside the back hall exit door. The resident denied this and stated she was going to use her phone. Per the note, the SW encouraged

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Resident #104 to use the patio areas and the resident stated she did not like the non-smoking patio area. SW informed the resident she could go out on the smoking patio during smoke breaks with other residents but she could not smoke per the policy. The note continued "Resident was then caught smoking by DNS (Director of Nursing Services) and ED (Executive Director) and was informed she could not smoke. SW informed her again of the policy and the resident voiced understanding.

Interview with the DNS on 04/24/13 at 3:13 PM revealed she and the ED were coming down the hall on 04/15/13 when they saw Resident #104 smoking outside in the smoking area under the canopy. When DNS and ED got outside, Resident #104 denied smoking, but there was evidence on the ground of ashes and the DNS saw a cigarette and lighter in her lap blanket. The DNS stated she was wearing the oxygen tubing nasal cannula in her nose, however, stated the tank was observed turned off which was on the back of her wheelchair. The DNS stated she removed the cigarette and lighter, handed them to the ED and had the SW speak to the resident again about the policy.

The care plan was not changed after this event.

A nursing note dated 04/20/13 at 1:38 PM stated "Staff reported that earlier resident was smoking in her bathroom. Resident denied this but later admitted it and lighter was removed by nurse from room. Patient teaching was done regarding danger of smoking with 02 (oxygen) use. Resident stated she understood and that it would not happen again." Review of the "Verification of

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Investigation" dated 04/20/13 at 2:41 PM revealed a nurse aide reported Resident #104 was smoking in her bathroom and resident was on oxygen. This form stated the recommendations and interventions were:
*education to the resident;
*education to staff regarding the smoking policy; and
*a smoke detector was placed in Resident #104's bathroom.

A care plan addressing behaviors initiated on 03/19/13 was updated on 04/22/13 with a hand written addition to the focus of the resident smoking in her bathroom. There was no goal to this additional focus and the interventions added included "smoke detector to be placed in res. BR (resident's bathroom)" and "educate res on dangers of smoking in facility."

On 04/24/13 at 10:55 AM the SW was interviewed and stated on 04/22/13 it was brought to her attention during morning meeting that Resident #104 was caught smoking in her bathroom over the weekend. The SW stated a smoke detector was placed in the resident's bathroom, staff were educated not to allow the resident to go out back unsupervised, staff educated to redirect the resident to patio areas and the nurses were educated to maintain good documentation of smoking incidents. She stated that she then updated the care plan relating to smoking with the new focus addition that Resident #104 was non-complaint with the smoking policy. SW stated the goals were included in the computer software and the goal to have no smoking related injuries was the closest care plan goal to the problem available. The SW

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stated she could have edited and developed a more appropriate goal but did not. She also stated that the only time a care plan was discussed was after the incident where Resident #104 was caught in the bathroom smoking. Per the SW that was when the behavior care plan was updated with the addition of the smoke detector in the bathroom and re-educating the resident. The SW stated she failed to include the staff education, and the additional visual checks the staff were to do on Resident #104 anytime they passed her room in an attempt to see smoking materials she may have in her possession. She stated no plan was developed to prevent Resident #104 from obtaining smoking materials while out of the facility or from visitors and from hiding them in her possession. Interview with SW on 04/24/13 at 1:10 PM revealed the Assistant Director of Nursing Services (ADNS) added the smoke detector and education to the behavior care plan.

On 04/24/13 at 12:59 PM, Resident #104 was interviewed and admitted to smoking in the bathroom once and got in trouble for it. She stated she used to have a lighter and cigarette but gave them to the nurse. She stated she also smoked outside once but took her oxygen off. Resident #104 was observed transferring herself from the wheelchair to the bed. She was observed with very shaky arm and leg movements of both extremities.

Interview with the DNS on 04/24/13 at 3:13 PM revealed staff had been educated to report smoking materials found, to watch Resident #104 more closely, to reeducate the resident on the smoking policy and to be aware that a smoke

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detector had been placed in the resident's bathroom. There was nothing planned to check the resident for smoking materials when she left the facility and returned or had visitors.

On 04/25/13 at 2:58 PM, the ADNS stated she updated the care plan on Monday (04/22/13) at the clinical start up meeting. She stated staff discussed behaviors but had not developed a care plan for non-complaint smoking even though she had been caught smoking outside on the premises. She stated that staff just followed the behavior care plan approaches.

On 04/25/13 at 3:17 the SW stated she updated the care plan relating to smoking on 04/24/13 to include the resident's noncompliance under the focus area. She stated she did not add any other interventions. She further stated that a care plan was never discussed in morning meetings to address Resident #104's smoking until 04/22/13 with the addition of the smoke detector under the behavior care plan.

On 04/25/13 the Executive Director was informed of the immediate jeopardy. An acceptable allegation of compliance was received on 04/26/13 which stated:

Golden Living Center Asheville is alleging abatement of jeopardy on 4/25/13. On 4/25/13 the Executive Director was notified of an Immediate Jeopardy related to a Care Plan for resident #104 that did not address the resident's high risk for and history of non-compliance with the facility smoking policy.
Immediately upon notification of the Immediate Jeopardy the following was initiated:

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F 279	Continued From page 26 On 04/04/13, Social Services Director developed a Smoking Care Plan. On 4/25/13 at approximately 3:30 pm Social Services Director updated resident #104's care plan to include verbiage related to the resident's history of being non-compliant with the smoking policy, specifically: 04/04/13, Smoking Care Plan Developed 04/04/13, Review smoking policy with patient and/or family 04/21/13, Added smoke alarm to resident bathroom 04/24/13, Initiated 1:1 continuous direct staff supervision while in residence 04/25/13, Offer substitutions for smoking such as nicotine patches, electronic cigarettes 04/25/13, Searched resident room and belongings for smoking materials. 04/25/13, Staff will report immediately to supervisor/charge nurse any breach of the smoking policy. On 4/25/13 at 5:30 pm, the Reimbursement Consultant began educating the Interdisciplinary Team, which includes Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Director of Clinical Education, Dietary Manager, Registered Nurse Assessment Coordinator about: updating resident #104's Care Plan who was non-compliant with the Smoking Policy to include all of the above interventions dated 04/25/13. Specific interventions were added to Care Plan with non-compliance of Smoking Policy as of 04/25/13. On 4/24/13 at approximately 5:30 pm the Nursing Services Consultant reassessed all center residents regarding smoking history or a potential risk for smoking in the future. Center identified 6	F 279		

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smoking residents that were grand-fathered in as of 11/1/12, who answered yes to being a smoker on the smoking assessment. Therefore, a new smoking safety assessment was completed and the Care Plans were audited and updated to include the following interventions:
04/25/13, 1:1 continuous direct staff supervision for 72 hours, and then re-evaluate for those residents found in breach of the smoking policy.
04/25/13, Educated regarding smoking policy and hazards of non-compliance of Smoking Policy
On 4/24/13 at approximately 6:00 pm the Social Services Director re-educated all 6 smoking residents regarding the smoking policy.
On 4/25/13 at 5:30 pm, the Reimbursement Consultant began educating the Interdisciplinary Team, which includes Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Director of Clinical Education, Dietary Manager, Registered Nurse Assessment Coordinator about:
Specific examples related to time frames for auditing and updating Care Plans when presented with non-compliance of Smoking Policy
All newly admitted residents will be reviewed by the Nursing and Social Services Interdisciplinary Team during the next daily Clinical Start-Up meeting after admission to discuss smoking history and determine potential future smoking risks and ensure Care Plan interventions address risk of non-compliance with Smoking Policy for residents deemed high risk.
On 4/26/13, Social Services will mail letter to all family members regarding smoking policy, residents not allowed to have smoking materials in their possession and that if out of facility, will be required to relinquish smoking materials to facility staff upon return to facility. Family members will

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F 279	Continued From page 28 be re-educated at the next scheduled Family Night on May 29, 2013. On 04/25/13 at 5:15 pm, as a result of finding smoking paraphernalia in the residents' rooms on 4/24/13, Care Plans for two of the six identified smoking residents were updated to include: 04/25/13, Initiated 1:1 staff supervision secondary to non-compliance with smoking policy for 72 hours; then re-evaluate 04/25/13, Educate each resident regarding hazards of non-compliance with smoking policy Monitoring of the Systems includes: Until 05/24/13, the Director of Nursing will review each new resident's Smoking Assessment to determine appropriate level of risk and appropriate Care Plan interventions based upon resident's history of tobacco use. Until 05/24/13, the Executive Director will review 10% of new resident Care Plans to ensure appropriate interventions are in place according to Smoking Policy and resident's history of tobacco use. The Executive Director will present all results associated with changes to residents' care plans, and any changes thereof, to the Quality Assurance and Process Improvement Committee each month beginning May 2013 for three months and then quarterly beginning August 2013 and ending December 2013. Immediate jeopardy was removed on 04/26/13 at 5:30 PM when interviews with nursing staff and other staff confirmed they had received in-service training on the facility's updated smoking policy and the development of a care plan for residents who verbally express a desire to smoke or exhibit behaviors indicating a desire to smoke.	F 279		

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F 279	Continued From page 29 Record reviews were also done to verify current smoking assessments and care plans for all affected known residents with a history of smoking. Observations were completed to ensure smoking was supervised, smoking materials were secured, and staff knew who the grandfathered residents were who were permitted to smoke in the facility's courtyard.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and resident interviews, the facility failed to keep fingernails trimmed and/or clean for 2 of 2 sampled residents. (Resident #48 and #16). The findings included: 1. Resident #48 was admitted on 03/30/12 with diagnoses including cerebral palsy. The annual Minimum Data Set (MDS), dated 04/08/13, coded Resident #48 as having no cognitive deficits, no behaviors, and requiring extensive assistance with hygiene and total dependence for bathing. He was coded as having upper and lower impairment for range of motion of extremities on both sides. The Care	F 312		

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F 312	Continued From page 30 Area Assessment related to activities of daily living skills, dated 04/08/13, stated he was dependent on staff due to cerebral palsy and contractures of the upper and lower extremities. He was described as being able to hold objects and move the knob on his electric wheelchair. The care plan related to self care impairment, last updated 04/04/13, included interventions for staff to anticipate his needs. On 04/22/13 at 4:44 PM, Resident #48 was observed in bed with a contracted right elbow, wrist and fingers. His fingernails on both hands were observed to be long, extending over his nail bed approximately a quarter of an inch. The nails on his left hand, the one he was capable of using, had a blackish substance under each nail. On 04/23/13 at 9:20 AM, he was observed in the hall in his wheelchair. His fingernails on both hands remained long and the ones on his left hand were soiled with blackish substance under the nails. On 04/24/13 at 1:06 PM, Resident #48 was observed in bed feeding himself with his left hand. Both hands had long fingernails and a blackish substance was observed under the nails on his left hand. On 04/25/13 at 12:15 PM Resident #48 was observed with long nails on both hands and blackish substance under the nails on his left hand. He stated at this time that the nurse aides cut his nails and further stated it had been "a while" since his nails were trimmed.	F 312		

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F 312	Continued From page 31 On 04/25/13 at 12:25 PM, Nurse Aide (NA) #4, responsible for his care on that date, stated she had not had time to check his nails or cut them. She stated she was unaware of their length or their dirt. She stated nails should be cleaned and trimmed on shower days and as needed. NA #5 stated at 04/25/13 at 2:21 PM that nail care should be provided on shower days. On 04/25/13 at 2:26 PM, Nurse #1 stated nails should be looked at and cared for on shower days. Resident #48's nails remained long and with a blackish substance under the nails on his left hand when he was observed on 04/25/13 at 2:56 PM. In reviewing the bathing and shower records, Resident #48 last received a shower on 04/16/13. He received a full bed bath on 04/23/13. Review of the nurse aides' bath and skin reports revealed Resident #48 was documented as having clean short fingernails on 04/16/13, 04/19/13, and 04/23/13. Interview with the Director of Nursing services on 04/25/13 at 6:50 PM revealed her expectation was that staff check fingernails and provide necessary care during showers and as needed. 2. Resident #16 was admitted to the facility on 05/12/11 with diagnoses including dementia. His annual Minimum Data Set dated 04/12/12 coded him as having severely impaired cognition,	F 312		

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no behaviors, requiring extensive assistance with hygiene and total dependence with bathing. The care area assessment dated 04/24/12 for cognition stated he had long and short term memory impairments and severe decision making skills and staff must anticipate his needs. There was no assessment for activities of daily living skills. There was no care plan relating to hygiene or bathing.

Resident #16 was observed on 04/22/13 at 5:09 PM in bed with long nails that were smooth edged and clean but extended over his nail beds almost a quarter of an inch. His nails remained long during the observations on 04/23/13 at 2:00 PM and on 04/24/13 at 9:05 AM. On 04/24/13 at 9:05 AM Resident #16 stated he was agreeable to having his nails trimmed.

On 04/25/13 at 12:25 PM, Resident #16's nails on his right hand had been cut and left jagged. His left hand remained unchanged with long nails. Nurse Aide (NA) #4 stated at this time, she had not had time to cut nails this date. She further stated nails should be cut during shower days and as needed.

On 04/25/13 at 2:21 PM, NA #5 stated nail care should be done on shower days.

On 04/25/13 at 2:26 PM, Nurse #1 stated nails should be looked at on shower days and cared for as needed.

Review of the shower records revealed Resident #16 was provided a shower on 04/17/13 and 04/24/13.

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F 312	Continued From page 33 Review of the nurse aides' bath and skin reports revealed his fingernails were noted as short and clean on 04/13/13, 04/17/13 and 04/24/13. Interview with the Director of Nursing services on 04/25/13 at 6:50 PM revealed her expectation was that staff check fingernails and provide necessary care during showers and as needed.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview and resident interview, the facility failed to apply a splint as ordered for the treatment of a contracture for 1 of 3 sampled residents. Resident #48. The findings included: Resident #48 was admitted on 03/30/12 with diagnoses including contractures of upper and lower extremities. The annual Minimum Data Set (MDS) dated 04/08/13 coded Resident #48 as having no cognitive deficits, no behaviors, and requiring extensive assistance with hygiene and total	F 318		

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dependence for bathing. He was coded as having upper and lower impairment of extremities on both sides related to range of motion.

The Care Area Assessment related to activities of daily living skills dated 04/08/13 stated he was dependent on staff due to cerebral palsy and contractures of the upper and lower extremities.

The care plan related to self care impairment, last updated 04/04/13, included the goal to maintain current range of motion due to history of severe contractures in the right upper extremity. Interventions included splints as ordered as resident allows and therapy screens as indicated.

Physician orders for April 2013 included:
*02/12/13 apply right elbow splint for 6 hours with good skin integrity once a day on day shift everyday.
*02/29/13 Resident #48 to wear a right hand and elbow splint for 6 hours per day and/or while sitting in powered wheelchair.

Review of the Resident Cardex, which contained specific care information about each resident for use by nurse aides, revealed directions for Resident #48 to wear a "left" arm brace. There was no time frame noted in these directions.

On 04/23/13 at 9:20 AM Resident #48 was observed in his wheelchair in the hallway. There was no splint on his right upper extremity. His elbow was severely bent upward and his hand was severely bent down to his forearm.

Resident #48 was observed on 04/24/13 at 9:01 AM, at 10:41 AM, and at 12:05 PM in bed, asleep

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F 318	Continued From page 35 with no right elbow splint in place. On 04/24/13 at 1:06 PM, he was observed in bed feeding himself using his left hand and there was no right elbow splint in place. On 04/24/13 at 2:46 PM Resident #48 was in the hall in his wheelchair with no right elbow splint in place. On 04/24/13 at 5:15 PM, Resident #48 was in bed without an elbow splint and he stated staff forgot to put it on him today. He further stated it happened occasionally. Follow up interview with Resident #48 on 04/26/13 at 9:15 AM revealed he was supposed to have his splint applied to his right elbow daily for around 6 hours. He stated sometimes the aides put it on and sometimes they did not. He stated the reason seemed to him that if an aide does not know how to apply it, they give up and don't put it on. Some aides know how to put it on and some don't. Interview with the Regional Rehab Director on 04/26/13 at 9:45 AM revealed Resident #48 had been on the occupational therapy caseload but was discharged on 01/22/13. Resident #48 was referred to nursing for splint application. An initial training of nursing staff was held for the splint application and therapy was available whenever needed. Review of the Treatment Administration Record revealed the elbow splint was documented as being in place all of April 2013 except for 04/14/13. It was noted as being in place during	F 318		

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F 318	Continued From page 36 first shift on 04/22/13 and on 04/24/13 by Nurse #1.	F 318		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and resident interviews, the facility failed to supervise and implement interventions for 1 of 7 sampled residents who was non-compliant regarding the facility's smoking rules and smoking while wearing oxygen. (Resident #104). Immediate Jeopardy began on 04/15/13 when Resident #104 smoked on the facility premises wearing oxygen with no interventions made by staff other than reminding the resident of the nonsmoking policy. Immediate jeopardy was removed on 04/26/13 at 5:30 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.	F 323		

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F 323	Continued From page 37 The findings included: The facility provided evidence in the form of a letter dated 10/30/12 "To Whom It May Concern" which informed the reader that on 11/01/12 a new policy went into effect which made the facility a smoke free building. The policy was effective for all residents, families and visitors. The policy stated new residents admitted to the facility must adhere to the policy on admission. The policy stated "Smoking is prohibited on the grounds of Golden Living Center including outside building entrances, courtyards, parking lots and inside building. 'No Smoking' signs will be posted in the restricted areas." The facility's smoking policy last reviewed and revised April 2013 stated that "While Golden Living Center-Asheville will continue to allow residents who chose to smoke tobacco products the privilege of smoking in approved areas and at approved times. Smoking will only be allowed as outlined in this policy and will be monitored for compliance and enforced. This policy will be distributed upon admission to each resident and their responsible party." The guidelines included: *All material related to smoking will be stored at the nursing stations; *Each resident smoker will be assessed for their own individual abilities and circumstances and care planned for this ability; *Smoking is not permitted inside the building. The designated area for smoking is located in the facility courtyard; *Oxygen use is prohibited in smoking areas; *Smoking times are established and smoking is	F 323		

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F 323	Continued From page 38 permitted only in the designated area and during acceptable weather; *Any resident, visitor or associate who does not comply with the facility rules regarding smoking may be asked to forfeit smoking or visiting privileges. If the danger of lack of compliance is serious enough, it may warrant discharge in accordance with state and federal law. Resident #104 was admitted to the facility on 03/05/13 with diagnoses including end stage chronic obstructive pulmonary disease (COPD), chronic respiratory failure, hypertension, tobacco use, depression, anxiety and bipolar disease. Physician orders since admission included continuous oxygen at 4 liters per minute. Resident #104 was also under the care of Hospice services for end stage COPD and pain management. Resident #104 signed the "Acknowledgement of No Smoking Policy" on 03/05/13 which stated the resident had been informed that the current regulation under House Bill 1294 was that residents sign acknowledgement that smoking was prohibited in all long term care facilities. Resident #104 was her own responsible party. Nursing notes dated 03/05/13 included the resident was "Alert and oriented x 3, although appears very drowsy. Makes needs known verbally. Answers questions appropriately, voice with soft tone." Review of the History and Physical/Admit Note dated 03/08/13 revealed Resident #104 was transferred to this facility from a sister facility via a Hospice house. This admit note stated the resident had reported she quit smoking. The "assessment/plan" per this note stated she was oxygen/steroid dependent, had questionable	F 323		

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ongoing tobacco use and questionable history of substance abuse. There was nothing ordered to address her possible tobacco addiction.

The admission Minimum Data Set for Resident #104, dated 03/12/13, coded her moderately impaired in decision making skills (scoring a 12 out of 15 on the Brief Interview for Mental Status), feeling down, requiring limited assistance for bed mobility, transfers, walking in room, hygiene and toileting. She was unsteady and needed assistance to stabilize her balance. There was no care plan which addressed her previous tobacco use.

Indications that Resident #104 had desires/behaviors of smoking were:

A. Nursing notes dated 03/13/12 at 3:44 PM revealed Resident #104 "requested to smoke today, explained the facility smoking policy. Res (Resident) tearful, reported to ADNS (Assistant Director of Nursing Services)." There was no evidence in the medical record that the physician was notified of Resident #104's desire to smoke.

B. Nursing notes dated 03/15/13 at 12:05 AM stated that the resident was denying she received her narcotic medication and demanded to have a breathing treatment which was not ordered. She was noted as going through her bag and took out a cigarette lighter. The resident was noted to be going up and down the hall, rolled to back door and stated she wanted to go outside to smoke. Per the nursing note, the nurse explained the resident was using oxygen and was unable to be around open flames. The resident went to the nursing desk and stated she was a little confused.

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There was no indication in the medical record that the physician was notified of her desire to smoke. The note did not address what happened with Resident #104's lighter.

C. Review of nursing notes from 03/16/13 through 04/03/13 revealed no indication of Resident #104 expressing or showing any desire to smoke. On 04/04/13 at 3:58 PM, a social service note stated the social worker (SW) met with Resident #104 regarding the smoking policy due to resident inquiring about smoking on campus. The SW informed the resident that as of 11/01/12 no new admissions were allowed to smoke on facility campus. Per the note, the resident stated she does not smoke at the facility and understood the policy. SW informed the resident that going against the policy could mean discharge to another facility. Resident #104 voiced understanding.

An interview with the SW on 04/24/13 at 10:55 AM revealed that on 04/04/13 it was brought to the SW's attention that Resident #104 was caught smoking out the back door in the parking area the weekend before (March 30-31st). The SW stated either a nurse aide or a manager on duty (she could not recall specifically who) informed her on 04/04/13 about the previous weekend so she spoke to Resident #104 on 04/04/13 about the smoking policy and possible discharge from the facility for noncompliance. Resident #104 voiced understanding.

Interview on 04/24/13 at 5:00 PM with the medical record clerk who also worked as Manager on Duty (MOD) revealed that she worked 03/31/13. She stated she saw Resident #104 going out the

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back door. Resident #104 told the medical record clerk she was going outside to smoke with one of the nurse aides. The medical record clerk stated she went out the back and a nurse aide (she could not recall who) agreed to sit with Resident #104. The medical records clerk stated she did not stay and see if smoking occurred. She further stated that supervised residents smoke in the courtyard and she thought staff smoked in the back. She stated she could not recall if Resident #104 was wearing oxygen. The medical records staff stated she was not familiar with the facility's nonsmoking policy. She further stated she did not report this incident until this past Monday's (04/22/13) morning meeting.

A care plan initiated 04/04/13 had the focus that Resident #104 was "At risk for smoking related injury related to history of smoking incidents." The goal was "will have no smoking related injuries." The only intervention was "Review smoking policy with patient and or family."

D. Notes dated 04/15/13 at 3:15 PM by the SW revealed that the housekeeping staff informed the SW that Resident #104 was attempting to smoke outside the back hall exit door. The resident denied this and stated she was going to use her phone. Per the note, the SW encouraged Resident #104 to use the patio areas and the resident stated she did not like the non-smoking patio area. SW informed the resident she could go out on the smoking patio during smoke breaks with other residents but she could not smoke per the policy. The 04/15/13 note continued "Resident was then caught smoking by (Director of Nursing Services) DNS and (Executive Director) ED and was informed she could not

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smoke. SW informed her again of the policy and the resident voiced understanding.

Interview with the DNS on 04/24/13 at 3:13 PM revealed she and the ED were coming down the hall on 04/15/13 when they saw Resident #104 smoking outside in the smoking area under the canopy. When DNS and ED got outside, Resident #104 denied smoking, but the DNS said she had seen the resident putting out her cigarette on the concrete slab and there was evidence on the ground of ashes. The DNS said she then saw a cigarette and lighter in her lap blanket. The DNS stated she was wearing the oxygen tubing nasal cannula in her nose, however, stated the tank on the back of her wheelchair was observed turned off. The DNS stated she removed the cigarette and lighter, handed them to the ED and had the SW speak to the resident again about the policy. Per the DNS, she assumed Resident #104 obtained the cigarettes and lighter when she went off the facility premises which she was allowed to do independently as she was her own responsible party. The DNS stated she had spoken to Resident #104's family member about the smoking materials and behaviors several times. There was no documentation provided regarding this intervention.

There was no evidence in the medical record indicating that the physician was notified of Resident #104 smoking or any request for interventions to address her nicotine addiction.

Interview with the SW on 04/24/13 at 10:55 PM revealed that because of Resident #104's smoking, a meeting was held on 04/19/13 with

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the resident and Hospice to discuss smoking issues. During this meeting, Resident #104 denied smoking and announced she was planning discharge to the community.

E. A nursing note dated 04/20/13 at 1:38 PM stated "Staff reported that earlier resident was smoking in her bathroom. Resident denied this but later admitted it and lighter was removed by nurse from room. Patient teaching was done regarding danger of smoking with 02 (oxygen) use. Resident stated she understood and that it would not happen again." Review of the "Verification of Investigation" dated 04/20/13 at 2:41 PM revealed a nurse aide reported Resident #104 was smoking in her bathroom and resident was on oxygen. This form stated the recommendations and interventions were:
*education to the resident;
*education to staff regarding the smoking policy; and
*a smoke detector was placed in Resident #104's bathroom.

On 04/24/13 at 1:20 PM, NA #2 stated she had clocked out on 04/20/13 around noon and was heading out the back door when she smelled smoke from Resident #104's room. Upon closer inspection, she found Resident #104 in the bathroom with her oxygen tubing in place and the room smelled very strongly of smoke. At that time NA #3 entered the room and took over Resident #104's care. NA #2 stated when she got to her car she called the ADNS at home about the incident.

On 04/24/13 at 2:53 PM the ADNS stated she received a call from NA #2 at home about the

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smoke in the bathroom and she called the DON and the MDS Coordinator who was the manager on duty. Per the ADNS Resident #104's request to smoke was discussed in morning meetings and that the SW spoke to the resident many times. The ADNS stated the plan since this weekend was to install a smoke detector in the bathroom and check on Resident #104 more frequently. Staff were also educated to report if they see lighters or cigarettes. ADNS stated the resident goes out of the facility and has visitors and it is suspected that was where she was obtaining smoking materials. The ADNS stated nothing was in place to check Resident #104 for smoking materials after having visitors or going out of the facility and returning.

On 04/24/13 at 12:49 PM, MDS Coordinator, who was the manager on duty when Resident #104 was caught smoking in the bathroom, was interviewed. The MDS Coordinator stated this past Saturday, the ADNS called her after receiving a phone call from a nurse aide that Resident #104 was caught smoking in the bathroom. The MDS Coordinator went to Resident #104 who agreed not to smoke anymore and handed the MDS Coordinator her lighter. The pack of cigarettes was empty. The MDS Coordinator stated she called the DNS who instructed the MDS Coordinator to give an in-service to first and second shift staff about the facility's smoking policy and to instruct staff not to allow smoking privileges for residents who were not in the facility prior to the change to a non-smoking facility (grandfathered in). The MDS Coordinator stated that staff were to let the nurse know right away if they saw Resident #104 with a lighter or cigarette. The MDS Coordinator

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provided this inservice per the DNS's instructions on 04/20/13.

Interview with the DNS on 04/24/13 at 3:13 PM revealed she instructed the MDS Coordinator who was manager on duty on 04/20/13 to educate the first and second shift on reporting smoking materials found, to watch Resident #104 more closely, to reeducate the resident on the smoking policy, and to remove smoking materials. Resident #104's smoking was discussed in morning meeting on 04/22/13. Per the DNS, Resident #104 was permitted to sign herself out and leave the building either with friends or by herself in a cab. She stated it was against Resident #104's rights to search her room or person when she returned from outings and there was nothing no plan to check the resident for smoking materials when she left the facility and returned or had visitors.

On 04/24/13 at 12:59 PM, Resident #104 was interviewed and admitted to smoking in the bathroom once and got in trouble for it. She stated she also smoked outside once but took her oxygen off. Resident #104 was observed transferring herself from the wheelchair to the bed. She was observed with very shaky arm and leg movements of both extremities.

On 04/24/13 at 10:55 AM the SW was interviewed and stated on 04/22/13 it was brought to her attention during morning meeting that Resident #104 was caught smoking in her bathroom over the weekend. Resident #104 originally denied it and then later admitted it. She promised she would not do it again. On Monday 04/22/13, the SW reviewed the nonsmoking

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policy again with Resident #104. It was also discovered that Resident #104 had no discharge plans and was staying in the facility. The SW stated she speculated that when Resident #104 left the facility on outings, she got lighters and cigarettes. The SW stated she explained to the resident this date the possibility of discharge if the behavior continued. The SW stated a smoke detector was placed in the resident's bathroom, staff were educated not to allow the resident to go out back unsupervised, staff were educated to redirect the resident to patio areas, and the nurses were educated to maintain good documentation of smoking incidents.

The behavior care plan initiated on 03/19/13 was updated on 04/22/13 by the ADNS with the focus of the resident smoking in her bathroom. There was no goal to this additional focus area and the the interventions added included "smoke detector to be placed in res. BR (resident's bathroom)" and "educate res on dangers of smoking in facility."

The smoking care plan was updated on 04/24/13 to include the resident's noncompliance with the smoking policy under the focus area. No other interventions were added on this care plan.

On 04/24/13 at 4:55 PM the DNS, in the absence of the ED, was informed of the immediate jeopardy. An acceptable allegation of compliance was received on 04/26/13 which stated:

Golden Living Center Asheville is alleging abatement of jeopardy on 4/25/13. On 4/24/13 the Director of Nursing was notified of an Immediate Jeopardy related to unsafe smoking

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F 323	Continued From page 47 regarding resident #104. Immediately upon notification of the Immediate Jeopardy the following was initiated: On 4/24/13 at approximately 5:00 pm Director of Nursing compiled timeline of root cause information for resident #104. Findings included interviews with staff to determine any observation regarding resident smoking and/or having smoking materials, review of resident medical record to determine education that had been completed with resident surrounding smoking protocol at the center, and any information included in resident #104's plan of care regarding smoking and/or non-compliance with smoking protocol. On 4/24/13 at 4:55 pm., resident #104 was placed on continuous 1:1 direct staff supervision until safe discharge can be coordinated. Facility staff were educated on required replacement protocols for breaks and shift changes. On 4/24/13 at 4:55 pm, resident #104 was notified and a room search was conducted by the Nursing Services Consultant. Resident was noted to have a package of cigarettes and a lighter in her possession that was confiscated by facility staff and locked in appropriate storage area. On 04/25/13, Resident #104's Care Plan has been reviewed and revised by the Nurse Specialist to include the following: 04/21/13, added smoke alarm to resident bathroom 04/24/13, continuous 1:1 direct staff supervision until safe discharge can be coordinated 04/25/13, Offer substitutions for smoking such as nicotine patches, electronic cigarettes 04/04/13, Review smoking policy with patient and/or family	F 323		

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F 323	Continued From page 48 04/25/13, Searched resident room and belongings for smoking materials. On 4/24/13 at approximately 5:00 pm the Nursing Services Consultant notified all facility residents that room searches would be conducted. Room searches were completed on 4/24/13 at approximately 6:00 pm. Two separate residents were found to possess smoking paraphernalia in their room; items were confiscated and 1:1 supervision for 72 hours initiated. On 04/24/13, the smoking assessment and smoking safety assessment were completed for all center residents with up-to-date information. These quarterly assessments (pink forms) will be completed quarterly, annually and with a significant change. On 4/24/13, reviewed and revised the Smoking Policy "Any non-compliance that has the potential to affect the health and/or safety of residents may result in discharge pursuant to state and federal laws; grand-fathering in of current smoking residents as of 11/01/12 and that future admissions would be non-smoking." On 4/24/13 at approximately 5:30 pm the Nursing Services Consultant reassessed all center residents regarding smoking history. Center has 6 residents who answered yes to the "Smoking Assessment" questionnaire; thus prompting a new "Smoking Safety Assessment" and updates to Care Plans to address safe smoking. On 4/24/13 at approximately 6:00 pm the Social Services Director re-educated all smoking residents regarding the newly revised smoking policy. On 4/24/13 at 9:00 pm, resident #104 was re-educated on the center smoking policy by the Social Services Director. On 4/26/13, Social Services will mail letter to all	F 323		

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family members regarding smoking policy, residents not allowed to have smoking materials in their possession and that if out of facility, will be required to relinquish smoking materials to facility staff upon return to facility. Family members will be re-educated at the next scheduled Family Night on May 29, 2013.
On 4/24/13 at 6:00 pm, the Nursing Services Consultant began educating present facility staff about the Smoking Policy, designated smoking areas, protocols regarding resident safety, and interventions when residents are non-compliant with smoking policy, including immediate reporting to the supervisor/charge nurse on duty of any breach of the smoking policy. Education continued on 4/25/13 by the Nursing Services Consultant and the Assistant Director of Nursing Services for facility staff present. On 4/24/13 and 4/25/13, competency tests were administered to all staff to ensure understanding of policy and safety hazards. On 04/25/13, all unscheduled staff were telephoned and informed that they must complete required education by 04/26/13 at 4:30 pm or prior to their next scheduled work shift.
Monitoring of the System includes:
On 4/24/13 at approximately 5:00 pm the Executive Director was notified via phone, who reviewed the updated Smoking Policy and gave final approval to the revised policy.
All newly admitted residents will be reviewed by the Nursing and Social Services Interdisciplinary Team during the next daily Clinical Start-Up meetings after admission to discuss smoking history and determine potential future smoking risks. The manager on duty will provide daily visits for seven days regarding smoking history and potential risks for smoking, provide education

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F 323	Continued From page 50 to resident of smoking policy and potential safety hazards, offer smoking alternatives per resident request and physician orders, and referral to psyche services as needed. Quarterly communication to center's smoking residents, their families or POAs regarding smoking policy, its adherence and the maintenance of smoking materials in locked area. Department Managers will observe and document on internal "Ace Round" form, a minimum of 26 assigned smoke breaks per month during daily facility rounds to include visualization of safe smoking practices, appropriate supervision, and general compliance with smoking policy for 6 months. Staff will validate using a checklist for receipt of cigarette and disposal. Staff will maintain container of cigarettes and disperse one at a time. All smoking materials will be kept under lock and key. Daily until safely discharged, the Executive Director will visit resident #104 and assess room for any smoking materials and validate his/her understanding of the Smoking Policy. Until 05/10/13, 30% of staff will be interviewed regarding smoking policy, knowledge of center smoking residents, and resident safety. From 05/13/13 to 06/01/13, an additional 15% of staff will be interviewed regarding smoking policy, knowledge of center smoking residents, and resident safety. After 06/02/13, 20% staff will be interviewed regarding smoking policy, knowledge of center smoking residents, and resident safety on a calendar quarterly basis. The Executive Director will present all monitoring results, and any changes thereof, to the Quality Assurance and Process Improvement Committee each month beginning May 2013 for three months and then quarterly beginning August 2013.	F 323		

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F 323	Continued From page 51 Immediate jeopardy was removed on 04/26/13 at 5:30 PM when interviews with nursing staff and other staff confirmed they had received in-service training on the facility's updated smoking policy and action to take when a resident requests to smoke or is found to have smoking materials in their possession. Record reviews were also done to verify current smoking assessments and care plans. Observations were completed to ensure smoking was supervised, smoking materials were secured, and staff knew who the grandfathered residents were who were permitted to smoke in the facility's courtyard.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, date and cover foods and beverages stored in the nourishment refrigerators/freezers and to maintain nourishment room areas, microwaves and ice coolers in clean condition to prevent cross contamination.	F 371		

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The findings included:

1. Observations of the facility's 200 hall nourishment room on 04/22/13 at 3:01 PM revealed the following:

a. Foods stored in the nourishment room's refrigerator/freezer, which had a sign on the front noting resident use only, revealed the following problems: an egg salad sandwich labeled with a resident's name dated 04/16/13, peanut butter sandwiches labeled with resident names dated either 04/16/13 or 04/18/13, an unlabeled and undated piece of cake covered only by a paper towel, an unlabeled and undated bowl of peaches and kiwi, and an uncovered and unlabeled large drink from a fast food restaurant.

Observations of the facility's 200 hall nourishment room's refrigerator on 04/23/13 at 3:40 PM revealed there was an undated and unlabeled egg sandwich stored in the refrigerator.

Further observations of the facility's 200 hallway nourishment room refrigerator on 04/24/13 at 10:51 AM revealed there were three egg sandwiches and two peanut butter and jelly sandwiches stored in the refrigerator that were undated and unlabeled.

On 04/25/13 at 5:40 PM an interview was conducted with the facility's dietary manager (DM). The DM stated that the kitchen staff were responsible for checking the facility's nourishment room refrigerators twice a day and were to remove any out of date items and ensure all foods were appropriately labeled, dated and

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F 371	Continued From page 53 covered. The DM stated left over food was permitted to remain in the refrigerator for three days and that all food that goes out for snacks should be labeled with resident names and dates. The DM further explained that if foods stored in the nourishment refrigerators were unlabeled and undated, she suspected that these foods were left over from resident meal trays and were placed in the refrigerators by the nurse aides. Interview on 04/26/13 at 6:50 PM with the Director of Nursing Services (DNS) revealed if a resident requests a food item be saved from their meal tray, the nurse aides should date and label the item when they place it in one of the facility's nourishment room refrigerators. b. Observations on 04/22/13 at 3:01 PM of the microwave in the facility's 200 hall nourishment room revealed the interior of the microwave was unclean with dried food spillages. Follow up observations of the microwave in the facility's 200 hallway on 04/23/13 at 3:40 PM, 04/24/13 at 10:51 AM and on 04/25/13 at 8:38 AM revealed the inside of the microwave remained unclean with dried food spills. On 04/25/13 at 1:00 PM an interview was conducted with housekeeping staff. The housekeeper stated she was responsible for wiping down the nourishment room's counter and mopping the floor, but it was not her responsibility to clean the inside of the nourishment room's microwave. On 04/25/13 at 5:40 PM interview with the dietary manager revealed it was not the responsibility of	F 371		

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the dietary staff to keep the nourishment room microwaves clean and was unsure which department was responsible for cleaning these microwaves.

Interview on 04/26/13 at 6:50 PM with the Director of Nursing Services (DNS) revealed dietary staff or housekeeping staff were responsible for cleaning the microwaves in the facility's nourishment rooms.

2. On 04/22/13 at 3:01 PM the ice bucket in the 200 hall nourishment room was observed to have an ice scoop stored in the holder that was on top of a paper towel which covered three rusty screw heads. Under the ice bucket was a plastic deep tray with dark residue, a type of linen stuck to the bottom of this deep tray and a spoon.

Further observations of the facility's 200 hallway ice bucket on 04/22/13 at 5:23 PM, revealed an ice scoop was lying with the handle directly on top of the ice stored in the bucket. Observations under the bucket revealed dried sticky spills, a loose hair, a item of linen stuck to the tray and a spoon on the bottom shelf.

On 04/25/13 at 2:38 PM, Nurse Aide (NA) # 4 stated that she thought the nurse aides were responsible for cleaning the hallway ice buckets.

Interview on 04/26/13 at 6:50 PM with the Director of Nursing Services (DNS) revealed nursing and dietary were responsible for cleaning the facility's ice carts and the ice scoops should not be stored in the ice.

3. Observations of the facility's 100 hallway

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F 371	Continued From page 55 nourishment room revealed the following problems: a. On 04/22/13 at 3:30 PM, the inner compartment of the microwave in the facility's 100 hall nourishment room was observed to be unclean with a large accumulation of dried food splatters. Observations on 04/23/13 at 3:35 PM, also revealed the inner compartment of the microwave in the facility's 100 hall nourishment room remained soiled with dried food splatters. On 04/25/13 at 5:40 PM interview with dietary manager revealed it was not the responsibility of the dietary staff to keep the nourishment room microwaves clean and was unsure which department was responsible for cleaning these microwaves. Interview on 04/26/13 at 6:50 PM with the Director of Nursing Services (DNS) revealed dietary staff or housekeeping staff were responsible for cleaning the microwaves in the facility's nourishment rooms. b. Observations on 4/25/13 at 4:45 PM in the 100 nourishment room revealed there were flies on the wall behind and next to refrigerator/freezer, brown stains on side of ice machine and accumulated food debris in the sink's drain and on the counter behind the sink. On 04/25/13 at 3:14 PM interview with Unit Manager (UM) revealed all staff share responsibility for cleaning nourishment room. She stated any staff person from dietary,	F 371		

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F 371	Continued From page 56 housekeeping, or nursing was expected to clean up any stain they see when using the nourishment room. Interview on 4/26/13 at 2:09 PM with the housekeeping manager revealed his expectation was that deep cleaning was done on both of the facility's nourishment rooms each Saturday and monitored by housekeeping staff daily. The housekeeping manager stated that he had not checked the nourishment rooms for cleanliness since last week.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility staff failed to wash their hands before directly handling the food of Resident #48 after repositioning his roommate. This involved 1 of 3 staff observed setting up meal trays and Resident #48.

The findings included:

On 04/22/13 at 6:19 PM, Nurse Aide (NA) #6 was observed passing trays to residents in their rooms. She set up a resident's tray and moved the meat patty and lettuce around the bun with her bare hands in order to apply mayonnaise and ketchup from packets. She then proceeded to go to the cart and retrieve Resident #48's tray. Once the tray was set on Resident #48's overbed table, NA #7 asked NA #6 to assist him in repositioning Resident #37. After this resident was repositioned, NA #6 went immediately to Resident #48's tray, uncovered his plate, removed his utensils from their wrapper and with bare hands,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM RD 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 441	Continued From page 58 placed one hand on top of the sandwich so she could cut the sandwich in half. At no time did NA #6 wash her hands or use any other device to handle the residents' food. On 04/22/13, directly after the above observations, NA #6 was interviewed regarding hand washing. NA #6 stated she had been trained to wash her hands during tray passing only if she had direct contact with a resident and if she touched her face or hair. She stated she should have washed her hands after she repositioned the resident in bed. On 04/16/13 at 6:50, the Director of Nursing Services stated staff were expected to wash their hands after they touched or provided care to a resident before moving on to another resident. She also stated she would have expected staff to wear gloves if they were going to directly touch a resident's food.	F 441		