STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	A. BUILDING _____ B. WING _____	C 03/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE NURSING & REHABILITATION CENTER	**91 VICTORIA ROAD ASHEVILLE, NC 28801**

(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	F 000		

483.25 (F323) at K
Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/15 at 7:45 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 E (a pattern, 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 related to resident smoking.

483.75 (F490) at K
Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/15 at 7:45 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 E (a pattern, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2015

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F 000	Continued From page 1 into place are effective related to resident smoking. 483.75 (F520) at K Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/15 at 7:45 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 E (a pattern, 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 related to resident smoking. An amended Statement of Deficiencies was provided to the facility on 04/20/15 because citation F-279, was added to the facility's 2567 report. Event ID# OTJR11.	F 000		
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	F 159		4/17/15

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F 159	Continued From page 2	F 159		

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 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.

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F 159	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Business Office Manager the facility failed to identify a Medicaid resident with greater than 2000 in his resident trust account. (Resident #52) The findings included: Record review revealed Resident #52 had a balance greater than $2000.00 in the resident trust account for the past 3 months. 01/31/15 end of month balance for Resident #52=$2027.51 02/28/15 end of month balance for Resident #52=$2081.51 03/28/15 end of month balance for Resident #52=$2130.51 On 03/28/15 at 2:34 PM the Business Office Manager (BOM) stated she took over the resident trust account the end of January after a former business office employee terminated employment with the facility. The BOM stated she knew there were problems with the resident trust account. The BOM verified the payment source for Resident #52 was Medicaid. The BOM stated they were aware of one other resident on Medicaid that had a balance greater than $2000 in his resident trust account and efforts were being made to address the concern. The BOM stated she was not aware Resident #52 had greater than $2000 in the end of month balance in the resident trust account the past 3 months and was aware the concern should be addressed with the resident/responsible party. The BOM stated she usually notified the resident/responsible party when the account	F 159	"This plan of correction is the facility's credible allegation of compliance" Preparation and executive of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared or executed solely because it is required by provisions of federal and state law. The facility wtth written authorization of a resident will hold, safeguard, manage and account for the personal funds. Funds in excess of $50 will be held in an interest bearing account that is seperate from any facility operating accounts. The facility will ensure there is no comingling of funds by having a seperate interest bearing account. Quarterly statements will be given to the resident or his or her designee.The facility will notify each resident when they are witin $200 of the allowed limit if they are a Medicaid or SSI reciepient. Resident #52 balance is $1679.03. All resident balances were checked to ensure that no resident is over the allowed limit or within $200 of the allowed limit. Quarterly statements were mailed on April 15, 2015. The BOM and Administrator will review 2	

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F 159	Continued From page 4 balance was between $1500-$1700.	F 159	times per month the balances in each resident trust account to ensure that no account is over the allowed limit or within $200 of the allowed limit which could affect their Medicaid or SSI eligibility. The resident or responsible party will be notified by the BOM or Social Worker with a phone call and documented on the account if the account is nearing the limit that would affect Medicaid or SSI eligibility. Efforts will be made to work with the resident or responsible party to educate them on items that the resident may need purchased. The BOM will present to the QA committee the results of the audits each month to the QAPI committee for a period of 3 months.	
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview with the Business Office Manager and review of the surety bond and record review the facility failed to maintain adequate coverage in the surety bond for 3 of 4 months from November 2014-February 2015. The findings included:	F 161	The facility will maintain a surety bond for all personal funds of residents deposited in the facility. The bond was increased from $30,000 to $50,000 on 4/1/2015. The CFO will be notified monthly by email	4/17/15

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F 161	Continued From page 5 The current facility surety bond provided by the Business Office Manager (BOM) on 03/28/15 at 2:34 PM covered $30,000. Review of the end of month balance in the resident trust accounts from November 2014-February 2015 noted the balance as follows: November balance=$33,804.39 December balance=$34,013.90 January balance=$34,919.98 February balance=$29,835.33 On 03/28/15 at 2:34 PM the BOM stated she had taken over the resident trust account the end of January when a former business office employee terminated employment with the facility. The BOM stated she knew there were problems with the resident trust account but was not aware the surety bond did not provide full coverage for the amount of monies in the resident trust account for 3 of the past 4 months.	F 161	correspondence of any required changes in the surety bond to ensure compliance. The BOM will review monthly the balances in each resident trust to ensure that it does not exceed the surety bond amount. The BOM will email the Administrator and CFO the balance in the resident trust versus the bond amount. The Administrator will sign that it has been reviewed and is in compliance each month. The Administrator will report audit results to the QAPI committee on a monthly basis for a period of 3 months.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure toilets to the floor for 3 of 5 sampled bathrooms and failed to secure ceiling tiles for 1 of 5 sampled bathrooms. The findings included: An inspection of the facility occurred on 03/27/14	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Shower room 2 has been scraped,	4/17/15

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F 253	Continued From page 6 at 4:00 PM. The following environmental concerns were observed: a. In Shower Room 2 on the 100 hall, paint was observed to be bubbled, peeled, and chipped in various places. The toilet was observed to be loosened from its attachment to the floor and easily moveable 2 to 4 inches to the left and to the right. Additionally, there was moist, black debris around the base of the toilet. b. In Shower Room 6 on the 200 hall, the toilet was observed to be loosened from its attachment to the floor and easily moveable 2 to 4 inches to the left and to the right. c. In resident bathroom in room 211, the toilet was observed to be loosened from its attachment to the floor and easily moveable 2 to 4 inches to the left and to the right. d. In resident bathroom in room 212, a ceiling tile was missing from the ceiling and a black cord with a plug was observed to be hanging down from the ceiling 10 to 12 inches. An interview was conducted with the Maintenance Director on 03/27/15 at 4:20 PM. He stated he was not aware of the loose toilets or the bubbled, peeled, and chipped paint. He explained he was replacing a bathroom fan in Room 212's bathroom but had not yet completed the project. The Maintenance Director stated the facility was in the process of completing upgrades as quickly as possible, but would immediately secure the toilets to the floor. He explained staff were to put concerns in a maintenance book located at the 200 hall nurses' station. An interview was conducted with the Administrator on 03/27/15 at 4:52 PM. She explained there was a plan to update the building, and the plan was being carried out by the Maintenance Director and the Assistant Maintenance Director. The Administrator	F 253	prepped, and painted. The toilet has been secured to the floor. The moist black debris has been removed at the base of the toilet and it has been recaulked. Shower room 6 has been fully converted to a storage room. Room 211 toilet has been secured to te floor. Room 212 ceiling tiles have been installed and no cords are visible or exposed. Room 212 bathroom exhaust fan work has been completed. All staff were re-educated by the DON and RN Supervisor from March 28, 2015 to April 16, 2015 on reporting items in need of repair by entering them in the maintenance work order book at each nursing station. The education has been added to the orientation process. The Maintenance Director and Assistant are completing an audit tool 1-2 times per week in all rooms and shower rooms ensure that toilets remain secure, vents and ceiling tiles are in place, escheuteon plates, call lights are operational, A/C covers in place, wall in good repair, door closes and latches, there are no door obstructions preventing closure, and oxygen signs are in place. The facility has a room painting schedule that includes rooms, door jambs, shower rooms, halls, and corridors.	

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F 253	Continued From page 7 explained the plan included new paint and new light fixtures. She stated the toilets would be secured to the floor as soon as possible.	F 253	The audit tool is reviewed weekly by the Adminsrator and Director of Maintenance to ensure compliance. The Maintenance Director will report monthly the results of the audit to the QAPI committee for a period of 3 months.	
F 279 SS=E	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 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 review, and resident and staff interviews, the facility failed to develop or implement care plans for 10 of 17	F 279	The facility will use the results of the assessment to develop, review and revise the residents comprehensive plan of care.	4/17/15

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F 279	Continued From page 8 sampled residents who smoked. (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126 and #131). The findings included: The facility Smoking Policy (provided by the administrator on 03/25/15 from the facility admission packet) with revisions dated 01/01/13 and 01/08/15 included the following: -All residents that desire to smoke will be assessed upon admission, quarterly, and PRN (as needed), for level of safety awareness to determine if the resident is responsible, and what restrictions, if any, will need to be placed on the resident's smoking privileges. -The facility interdisciplinary team will then make the determination as to the above. -Based upon the smoking assessment, the resident may be required to wear a smoking apron and the resident care plan will be updated. -Information regarding smoking privileges, including restrictions, will be documented in the resident's care plan. 1. Resident #96 was admitted to the facility on 04/16/14 with diagnoses which included history of alcohol and tobacco abuse. The most recent Minimum Data Set (MDS) dated 01/21/15 assessed Resident #96 with no cognitive impairment. The Smoking Policy signed on admission by Resident #96 on 04/16/14 noted smoking material would not be kept in the resident's room. A "Safe Smoking Needs Assessment" was not available on the resident's medical record throughout his admission at the facility from	F 279	Our care plans will include measureable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that have been identified in a comprehensive care plan. The DON and RN Supervisor/Clincal Coordinator educated the staff on the smoking policy from March 28, 2015 to April 16, 2015. The smoking policy has been added to the orientation of new staff. No one was allowd to work untilt they have completed the education on the smokng policy. Resident #96 no longer resides at the facility. Resident #126 no longer resides at the facility. Resident #73 has had a safe smoking data collection tool completed and has been deemed a "safe smoker". Her care plan is reflective of the safe smoker designation. The resident is able to keep cigarettes in her room and is not required to lock them in any box or area of the room. The resident has signed the safe smoking policy and is aware of the guidelines to safe smoking. The resident is not allowed to keep any lighting materials in the room including lighter, butane, matches or other lighting material. Resident #86 has had a safe smoking data collection tool completed and is deemed an "unsafe smoker". His care	

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F 279	Continued From page 9 04/16/14 - 03/09/15. On 03/25/15 at 12:43 PM MDS Nurse #1 stated smoking assessments were completed on admission, quarterly and as needed. MDS Nurse # 1 checked the resident's closed medical record and electronic medical record on 03/26/15 at 10:35 AM and confirmed a smoking assessment had not been done on Resident #96. MDS Nurse #1 did not know why a smoking assessment had not been done throughout his stay at the facility. A care plan for Resident #96 dated 08/06/14 and last updated on 01/29/15 did not address the resident's smoking and/or smoking cessation. Summaries of Care Plan conferences completed on 10/29/14 and 01/28/15 both indicated Resident #96 smoked unsupervised. On 03/27/15 at 5:13 PM MDS Nurse #1 stated she could not explain why the care plan for Resident #96 did not address smoking. 2. Resident #126 was admitted to the facility on 03/03/15 with diagnoses which included chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated 03/10/15 assessed Resident #126 with no cognitive impairment and indicated Resident #126 used tobacco. A "Safe Smoking Needs Assessment" completed on 03/03/15 did not indicate any needs or issues with Resident #126 related to smoking. The Smoking Policy signed on admission by Resident #126 on 03/03/15 noted smoking material would not be kept in the resident's room. A care plan for Resident #126 dated 03/14/15 included a problem area that stated: "I am safe	F 279	plan reflects the "unsafe smoker" designation. The resident is not able to keep cigarettes, lighter or any other smoking items in the room or on his persons. The resident has signed the "unsafe smoker" policy. The resident is supervised by assigned staff members at designated smoking times and in the designated smoking area in the front courtyard of the facility. The resident is supervised by facility staff when rolling his own cigarettes with the machine and loose tobacco. The items needed to roll his own cigarettes is kept in the locked office of the Activty Department. All cigarettes that are rolled are then put in the secure smoking storage container at the 200 hall med room. Resident #131 had a safe smoking data collection tool completed and is deemed an "unsafe smoker". His care plan reflects the "unsafe smoker" designation. The resident is not able to keep cigarettes, lighter or any other smoking items in the room or on his persons. The resident has signed the "unsafe smoker" policy. The resident is supervised by assigned staff members at designated smoking times and in the designated smoking area in the front courtyard of the facility. The smoking supervisor assists this resident with smoking since he is unable to hold his cigarette. The resident does request to wear a smoking apron eventhough not required to since he is supervised by staff. The care plan reflects the resident choice to wear a smoking apron at this time. The care plan	

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F 279	Continued From page 10	F 279		

while smoking." Approaches to this problem area included: Educate my visitors about the smoking policy, Complete a Safe Smoking Assessment to identify my safety needs while smoking, Ensure that I/my responsible party understand the facility Smoking Policy.

On 03/25/15 at 11:44 AM an interview with Resident #126 in her room revealed she kept her cigarettes and lighter in an unlocked drawer in her nightstand. Resident #126 opened the drawer of the nightstand and showed the surveyor her cigarettes and lighter. The roommate of Resident #126 was observed with continuous oxygen in use via nasal cannula which was attached to an oxygen concentrator.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/03/15 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

3. Resident #73 was admitted to the facility on 02/24/15 with diagnoses which included chronic obstructive pulmonary disease and depressive. An admission Minimum Data Set (MDS) assessment dated 03/03/15 assessed Resident #73 with no cognitive impairment. The MDS indicated Resident #73 used oxygen.

A "Safe Smoking Needs Assessment" completed

will be revised based on the resident choice regarding wearing a smoking apron.

Resident #23 had a safe smoking data collection tool completed and is deemed an "unsafe smoker". His care plan reflects the "unsafe smoker" designation. The resident is not able to keep cigarettes, lighter or any other smoking items in the room or on his persons. The resident has signed the "unsafe smoker" policy. The resident is supervised by assigned staff members at designated smoking times and in the designated smoking area in the front courtyard of the facility.

Resident #36 has had a safe smoking data collection tool completed and has been deemed a "safe smoker". Her care plan is reflective of the safe smoker designation. The resident is able to keep cigarettes in her room and is not required to lock them in any box or area of the room. The resident has signed the safe smoking policy and is aware of the guidelines to safe smoking. The resident is not allowed to keep any lighting materials in the room including lighter, butane, matches or other lighting material.

Resident #44 has had a safe smoking data collection tool completed and has been deemed a "safe smoker". His care plan is reflective of the safe smoker designation. The resident is able to keep cigarettes in his room and is not required to lock them in any box or area of the

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F 279	Continued From page 11 on 02/25/15 did not indicate any needs or issues with Resident #73 related to smoking. The Smoking Policy signed on admission by Resident #73 on 02/24/15 noted smoking material would not be kept in the resident's room. Review of Resident #73's physician's orders revealed an order dated 02/24/15 for oxygen at 1 to 5 liters per minute to keep oxygen saturation levels above 90%. A care plan for Resident #73 dated 03/08/15 included a problem area that stated: "Resident is at risk for injury related to smoking activity due to potential for seizure." Approaches to this problem area included: Resident must smoke in designated areas only, during designated times, Resident to utilize smoking apron while smoking per facility policy, Staff to physically assist resident with smoking activity as needed, Monitor smoking habits and behaviors for poor safety and report, document and assess. On 03/25/15 at 10:05 AM Resident #73 was observed sitting outside in the designated smoking area with other residents. Resident #73 was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. During an interview with Resident #73 on 03/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she had been assessed as safe for smoking and didn't need to wear a smoking apron. On 03/25/15 at 11:40 AM Resident #73 stated	F 279	room. The resident has signed the safe smoking policy and is aware of the guidelines to safe smoking. The resident is not allowed to keep any lighting materials in the room including lighter, butane, matches or other lighting material. Resident #91 has had a safe smoking data collection tool completed and has been deemed a "safe smoker". His care plan is reflective of the safe smoker designation. The resident is able to keep cigarettes in his room and is not required to lock them in any box or area of the room. The resident has signed the safe smoking policy and is aware of the guidelines to safe smoking. The resident is not allowed to keep any lighting materials in the room including lighter, butane, matches or other lighting material. Resident #47 had a safe smoking data collection tool completed and is deemed an "unsafe smoker". His care plan reflects the "unsafe smoker" designation. The resident is not able to keep cigarettes, lighter or any other smoking items in the room or on his persons. The resident has signed the "unsafe smoker" policy. The resident is supervised by assigned staff members at designated smoking times and in the designated smoking area in the front courtyard of the facility. Supervised residents will not be required to wear a smoking apron during supervised smoking.	

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F 279	Continued From page 12 she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated: "We have a lot of people who wander and I figure if they can't see them they won't bother them." An oxygen concentrator with nasal cannula attached was observed beside the bed and Resident # 73 stated she used it all the time except when she went outside to smoke and she was getting ready to go outside to smoke. An interview with Nurse #5 on 03/25/15 at 5:15 PM revealed she was regularly assigned to provide care for Resident #73. Nurse #5 stated Resident #73 used the oxygen continuously when she was in her room and the only time she left the room was to go smoke. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/24/15 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. On 03/27/15 at 6:30 PM MDS Nurse #1 stated she was unaware the care plan for Resident #73 included an intervention for a smoking apron and was unclear if the smoking apron was indicated. 4. Resident #86 was admitted to the facility on 06/21/14 with diagnoses including tobacco use. Record review revealed a physician's order dated 06/25/14 for oxygen as needed (PRN) for shortness of breath and wheezing.	F 279	Care plans for all residents will be updated at least quarterly but more frequently if there is a significant change. Resident smoking care plans will be brought to the morning department manager meeting for review on a weekly basis or more frequently if necessary. The MDS/Care Plan Nurse will maintain the smoking compliance binder that will be reviewed at the morning department manager meeting. The Administrator and DON will review with the MDS nurse on a weekly basis and more frequently if necessary all resident care smoking care plans. The MDS/Care Plan team will put out a monthly calendar with the names of all the residents that will have updates due including care plans. The MDS/Care Plan nurse will report monthly for a period of 3 months all care plans that are associated with smoking residents.	

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The Smoking Policy signed on admission by Resident #86 on 06/21/14 noted smoking material would not be kept in the resident's room.
The most recent Minimum Data Set (MDS)dated 03/23/15 coded Resident #86 as cognitively intact with no mood or behavior problems and that he used tobacco.
A care plan dated 10/19/14 identified a problem of Resident #86 apt to smoke cigarettes in unauthorized areas secondary to disorientation and complaints from other residents, staff and visitors. This care plan was updated on 01/07/15 to continue the problem and again on 02/16/15 it was updated because Resident #86 had smoked in the building. Approaches included to allow Resident #86 to smoke in designated areas only with verbal reminders for him to put on a smoking apron.
Review of a "Safe Smoking Needs Assessment" for Resident #86 dated 03/25/15 revealed Resident #86 had dropped ashes on himself and the intervention indicated he continued to require a smoking apron.
On 03/25/15 at 9:54 AM Resident #86 was observed seated in his wheel chair in his room. The resident said he was going out to smoke. Observation of his over bed table revealed a plastic bag of loose tobacco with a machine for rolling cigarettes. Resident #86 stated he rolled his own cigarettes and kept the tobacco and lighter in his room. He said when he goes out to smoke he wears an apron.
On 03/25/15 at 12:43 PM MDS Nurse #1 stated staff who assess residents to smoke go outside and watch residents and determine if they are a safe smoker based on a residents ability to light their cigarette, extinguish their cigarette and if they dropped ashes on themselves when smoking. MDS Nurse #1 stated assessments are

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done on admission, quarterly and done again if there had been any change in the resident's mental status, medication changes, reports of physical changes and unsafe behaviors affecting resident's ability to smoke.
On 03/25/15 at 1:23 PM Resident #86 was observed to go out to the courtyard to smoke. When he arrived at the table to smoke he was observed to pick up a smoking apron lying on the back of the chair next to him and put it on with the material side out and not the shiny retardant material out. Observation revealed no staff directly supervising the smokers or available to assist Resident #86 to put the smoking apron on with the retardant side out.
On 03/25/15 at 6:14 PM Resident #86 was observed coming down the hall from smoking outside to return to his room. He was asked if he had his smoking materials with him and he answered yes and showed his empty pack of cigarettes and lighter. He stated that his cigarette pack was empty because he needed to roll more cigarettes.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 06/21/14 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

On 03/25/15 at 7:14 PM in a follow-up interview, MDS Nurse #1 stated Resident #86 required supervision while smoking to make sure he had

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his smoking apron on. MDS Nurse #1 stated Resident #86 had his own personal apron and that she was not aware of any instances of Resident #86 not putting his apron on correctly. MDS Nurse #1 stated after the incident in February 2015 when Resident #86 smoked inside the facility he was still considered a safe smoker because he could light his cigarette, extinguish his cigarette and wore a smoking apron to prevent a burn from ashes. For this reason, MDS Nurse #1 stated Resident #86 was allowed to retain smoking material in his room.

On 03/26/15 at 10:45 AM Resident #86's loose tobacco was observed stored in a plastic bag, in a box, and his rolling machine was observed on the over bed table with tobacco spilled out on the table from the machine. The bedside dresser did not have a locking drawer and Resident #86 stated he had not asked for a lock for the drawer.

5. Resident #131 was admitted to the facility on 03/13/15 with diagnoses including quadriplegia, visually impaired and tobacco use.
The smoking policy signed on admission by Resident #131 on 03/13/15 noted smoking material would not be kept in the resident's room.
The most recent Minimum Data Set (MDS) dated 03/20/15 coded Resident #131 as cognitively intact with no mood or behavior problems and that he used tobacco. His roommate had an order dated 06/25/14 for continuous oxygen at 3 liters per minute per nasal cannula for diagnoses of chronic obstructive pulmonary disease.
The care plan dated 03/22/15 identified a problem of Resident #131 at risk for injury related to smoking activity to include approaches that he must have direct supervision provided during the entire smoking period, monitor smoking habits

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and behaviors for poor safety and report, document and assess his ability to maintain safety during smoking, ensure he smokes in designated areas only and wears a smoking apron and resident's smoking materials were to be maintained by facility staff at all times.
Review of a "Safe Smoking Needs Assessment" for Resident #131 dated 03/25/15 noted resident with total or limited range of motion in arms and hands, diminished fine motor skills needed to hold a cigarette, drops ashes on self and unable to use ashtray to extinguish cigarette. The assessment noted Resident #131 required use of a smoking apron and for staff to extinguish his cigarette.
On 03/25/15 at 11:05 AM Resident #131 was observed being assisted by staff out to resident designated smoking area. Staff was observed to light Resident #131's cigarette, place the cigarette in his mouth, remove the cigarette from the Resident's mouth, flick the ashes in the ashtray, and place the cigarette back in Resident #131's mouth.
On 03/25/15 at 1:35 PM Resident #131 was observed seated in his wheel chair, in his room, waiting to be taken to a doctor's appointment. He was observed to have a pack of cigarettes lying on his lap with the lighter located in the cellophane cover of the cigarette pack. He stated he would put his cigarettes and lighter in his top drawer of his bedside table before he left for the doctor's appointment. Observations of Resident #131's bedside dresser revealed there was no lock on the drawer. An oxygen sign was on the outside of Resident #131's room and the roommate of Resident #131 was wearing a nasal cannula with oxygen being provided via an oxygen concentrator.
On 03/25/15 at 5:05 PM a cigarette pack and

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lighter were observed stored on the over bed table of Resident #131. Resident #131 had splints on both hands and his roommate was wearing a nasal cannula with oxygen being provided via an oxygen concentrator.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/13/15 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

On 03/25/15 at 7:30 PM an interview was conducted with the Admission Coordinator who had recently been hired. She stated she goes over the Smoking Policy with residents who smoke at the end of the admission process. She said all residents sign the Smoking Policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision.
On 03/27/15 at 5:13 PM an interview was conducted with MDS Nurse #1. She could not explain why Resident #131 would have cigarettes and lighter in his room noting he was a supervised smoker and it was inconsistent with what was in his care plan.
6. Resident #23 was admitted to the facility on 09/01/03 with diagnoses including depression and history of tobacco use.
The Smoking Policy signed by Resident #23 on

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04/29/13 noted smoking material would not be kept in the resident room.

The most recent Minimum Data Set (MDS) dated 03/02/15 assessed Resident #23 as cognitively intact with moderately impaired vision. His annual MDS dated 12/02/14 revealed he used tobacco.
Review of a "Safe Smoking Needs Assessment" dated 05/24/13 for Resident #23 revealed he had diminished fine motor skills, needed to securely hold his cigarette, he dropped ashes on himself and he must wear a smoking apron. Review of the "Safe Smoking Needs Assessment" form dated 03/25/15 revealed no problems.
A care plan dated 12/08/14 and updated on 03/02/15 identified a problem of Resident #23 at risk for injury related to cigarette smoking. Approaches included: supervision and use of a smoking apron, education on the danger/hazards of smoking, evaluate the resident for smoking level per policy to determine if he was a safe smoker or unsafe smoker.
On 03/25/15 at 1:06 PM Resident #23 was observed seated in his wheelchair in his room and he had a pack of cigarettes on his lap and was holding his lighter in his hand. Resident #23 stated he kept his cigarettes and lighter in the room because he was considered a safe smoker. Resident #23 also indicated he did not need a smoking apron.
On 03/25/15 at 1:22 PM Resident #23 was observed outside unsupervised in the smoking area. He was smoking and did not have a smoking apron on.
On 03/25/15 at 6:15 PM Resident #23 was observed coming down the hall from smoking outside in the designated area for residents to smoke. Resident #23 reported he had his

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smoking materials and lighter with him and was returning to his room.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 04/29/13 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

On 03/26/15 at 1:08 PM a follow-up interview was conducted with Minimum Data Set (MDS) Nurse #1. She stated Resident #23 was assessed as a safe smoker but must be supervised and wear an apron. MDS Nurse #1 revealed Resident #23 was a safe smoker because he could flick off his own ashes, light his own cigarette, take the cigarette out of the pack and put the cigarette to his mouth. MDS Nurse #1 stated some of Resident #23's clothes had holes and she did not know if the holes in his clothes were burns from cigarettes because there were no brown edges around the holes. MDS Nurse #1 stated Resident #23 was supposed to wear his apron and that staff supervising residents who smoked should know if a resident needed a smoking apron or not.

7. Resident #36 was admitted to the facility on 12/11/07 and readmitted on 08/17/12 with diagnoses including chronic airway obstruction. The Smoking Policy signed by Resident #36 on 04/29/13 noted smoking material would not be

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kept in the resident room.

The most recent Minimum Data Set (MDS) dated 02/09/15 coded Resident #36 as cognitively intact with no mood or behavior problems and use of tobacco.
A care plan dated 11/24/14 and reviewed 02/24/15 identified a problem Resident #36 was at risk for injury related to cigarette smoking. Approaches included to allow Resident #36 to smoke in designated smoking areas only, to encourage her to wear a smoking apron during smoke breaks because she nods off while smoking and has a history of lighting other residents cigarettes. In addition, another approach included that Resident #36's cigarettes and lighter must be locked up on the smoking cart.
Review of the "Safe Smoking Needs Assessment" dated 03/25/15 for Resident #36 revealed no problems.
On 03/25/15 at 10:58 AM Resident #36 was observed seated in her wheel chair out in the courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking with no smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarettes and lighter in her locked dresser drawer in her room.
On 03/25/15 at 11:52 PM Resident #36 was observed going to her room after she had smoked. Resident #36 reported she kept her cigarette and lighter in a case on her wheelchair during waking hours. Resident #36 stated she locked her cigarette and lighter in the drawer on the bedside table at night.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated

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they were unaware the Smoking Policy signed by the resident on admission 04/29/13 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

On 03/27/15 at 5:13 PM a follow up interview was conducted with MDS Nurse #1. She stated she did not realize the care plan for Resident #36 included an approach for cigarette and lighter to be locked in the smoking cart and for a smoking apron.

8. Resident #44 was readmitted to the facility on 11/06/14. Diagnoses included chronic obstructive pulmonary disease, incomplete quadriplegia, and spinal cord injury.

An annual Minimum Data Set (MDS) dated 10/10/14 indicated Resident #44 used tobacco. A quarterly MDS dated 01/09/15 indicated the resident was cognitively intact.

The Smoking Policy signed by Resident #44 on 11/07/14 noted smoking material would not be kept in the resident's room.

A review of the care plan revised 09/03/14 and 03/12/15 identified a problem area of Resident #44 wishing to smoke cigarettes. The goal was to keep the resident safe through the next review. Interventions included providing one-on-one supervision while smoking, nursing to keep cigarettes and lighter in a safe area, and to create a smoking schedule. The care plan did not identify a need for Resident #44 to wear a smoking apron.

A "Safe Smoking Needs Assessment" completed

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01/21/15 indicated no risk factors for smoking and no nursing interventions related to smoking. The tool also indicated the need for Resident #44 to wear a smoking apron while smoking.
On 03/25/15 at 12:49 PM, Resident #44 was observed smoking outside in the designated smoking area. He was not wearing a smoking apron and was not being supervised by a staff member.
Resident #44 was interviewed on 03/25/15 at 12:49 PM. He stated he went outside to smoke whenever he wanted. He explained he kept his cigarettes and lighter in a small bag attached to the right side of his wheelchair seat. Observation of the bag revealed a pack of cigarettes and a lighter were clearly visible.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 11/07/14 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

On 03/27/15 at 5:13 PM MDS Nurse #1 stated she could not explain why the care plan for Resident #44 indicated "nursing to keep cigarette and lighter in a safe place."
9. Resident #91 was readmitted to the facility on 12/25/14. Diagnoses included hypertension and coronary atherosclerosis.
An annual Minimum Data Set dated 03/17/15 indicated that Resident #91 used tobacco

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ASHEVILLE NURSING & REHABILITATION CENTER	91 VICTORIA ROAD ASHEVILLE, NC 28801

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products and was cognitively intact.
The Smoking Policy signed by Resident #91 on 02/11/14 noted smoking material would not be kept in the resident's room.
A "Safe Smoking Needs Assessment" completed on 12/25/14 for Resident #91 documented no risk factors for smoking and no nursing interventions to be implemented related to smoking. A "Safe Smoking Needs Assessment" completed 03/25/15 for Resident #91 noted no risk factors related to smoking but indicated the need of Resident #91 to wear an apron and have a cigarette holder when smoking.
A review of Resident #91's care plan revised 03/25/15 revealed a problem area of smoking. The goal was to keep the resident safe through the next review. The interventions included the resident wear a smoking apron and to provide periodic supervision when resident refused to wear the smoking apron.
Observation of Resident #91 on 03/25/15 at 5:14 PM revealed the resident was outside smoking. He was not wearing a smoking apron. His smoking was being supervised by the Administrator, the Director of Nursing, and the Social Worker.
On 03/26/15 at 8:54 AM Resident #91 stated the facility reviewed the smoking policy with him when he was admitted. He explained he knew the only place for him to smoke was the courtyard. He further explained he could keep his cigarettes and lighter on him, and he kept them in his pocket.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/11/14 included smoking material would not be kept in the

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resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.

10. Resident #47 was admitted to the facility on 12/18/13 and readmitted 02/05/15 with diagnoses which included paralysis, acute respiratory failure, history of traumatic brain injury, late effect hemiplegia and depression. The current Minimum Data Set (MDS) dated 02/10/15 assessed Resident #47 with no cognitive impairment. The significant change MDS assessment completed 07/04/14 assessed Resident #47 with use of tobacco.

The Smoking Policy signed on admission by Resident #47 on 12/18/13 noted smoking material would not be kept in the resident room.

A "Safe Smoking Needs Assessment" completed on readmission 02/06/15 did not indicate any needs or issues with Resident #47 related to smoking. A "Safe Smoking Needs Assessment" dated 03/25/15 for Resident #47 noted issues with "balance problem while sitting or standing", "diminished fine motor skills needed to securely hold cigarette" and "drop ashes on self". Interventions to protect the resident from injury was to "apply smoking apron".

The care plans for Resident #47 included the following problem areas and approaches:
A problem area dated 09/16/14 and updated 02/25/15 noted, "I am safe while smoking". Approaches to this problem area included: Apply

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smoking apron while I am smoking, Complete a Safe Smoking Assessment to identify my safety needs while smoking and Ensure that I/my responsible party understand the facility Smoking Policy.
A problem area dated 12/21/13 and updated 03/24/15 noted, "Resident is exhibiting non-compliance behavior". A care plan dated 07/23/14 and updated 02/25/15 noted, "Resident has episodes of yelling, screaming and cursing: refusing/resisting care and following facility policies with periods of agitation/angry outbursts".

On 03/24/15 at 11:20 AM Resident #47 was observed outside, smoking independently in the area designated for smoking. At the time of the observation, Resident #47 stated he kept his cigarette and lighter in his room either in his pocket or in a locked bedside drawer. On 03/25/15 at 11:06 AM a lighter was observed on the dresser, in the room of Resident #47. The door of the room was open and the lighter was in eyesight on the dresser in the room. Resident #47 (private room) was not in the room at the time of the observation. A second observation on 03/25/15 at 11:32 AM noted the lighter had been removed from the dresser. On 3/27/15 at 8:25 PM Resident #47 stated he never left a lighter on his dresser and could not explain how a lighter would have been left on the dresser. Resident #47 indicated he always kept smoking material in his pocket or locked bedside drawer.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 12/18/13 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care

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F 279	Continued From page 26 plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to obtain physician's orders to administer medicated eye drops as directed in post-operative discharge instructions for 1 of 1 residents reviewed for administration of eye medications following eye surgery (Resident #78). The findings included: Resident #78 was admitted to the facility on 11/16/11 with diagnoses including hypertension, bipolar disorder with psychotic features and Alzheimer's disease. Further review of Resident #78's medical record revealed a physician's progress note by an ophthalmologist dated 02/27/15 which indicated Resident #78 was seen for a post-operative visit following cataract surgery to the right eye on 02/20/15. There was not a progress note or any documentation on Resident #78's medical record that indicated the resident had cataract surgery on her left eye.	F 281	The facility will meet the professional standards of quality. The facility will obtain a physician order to administer eye drops if required by the physician. Resident #78 eye medication orders were clarified on 3/30/2015. The resident is receiving the eye medications as was prescribed by the physician on 3/30/2015. The DON and RN Supervisor/Clinical Coordinator re-educated nursing staff from March 30, 2015 to April 16, 2015, on documenting new orders including orders from outside physicians. All orders including those from outside physicians must be written on telephone order slips at each nursing station. A nurse will verify orders from outside	4/17/15

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F 281	Continued From page 27 Listed on the March 2015 MAR were: 1. Prolensa 0.07% instill one drop in operated eye every day after surgery (stop date?) with "L" written in above "operated eye" - the medication was documented as given 03/06 - 03/14/15. 2. Prednisolone Acetate 1% instill one drop in operated eye three times a day---start after surgery with "L" written in above "operated eye" - the medication was documented as given 03/06 -03/13/15. 3. Prednisolone Acetate 1% instill one drop in the right eye every day for ten days with "right" crossed out and "left" written in above it - the medication was documented as given 03/01 - 03/28/15. 4. Besivance 0.6% - starting 2 days before surgery instill one drop in operated eye three times a day with "L" written in above "operated eye" - the medication was documented as started on 03/04/15 and given three times a day through 03/28/15 at 2:00 PM. An interview with Nurse #6 on 03/28/15 about Resident #78's eye drops revealed Resident #78 had cataract surgery on her left eye on 03/06/15. Nurse #6 was unable to locate orders for eye drops to the left eye on the resident's chart and stated they might be in Medical Records. Upon request, the Medical Records coordinator checked for any unfiled documents for Resident #78 and located a physician's progress note from the ophthalmologist dated 03/13/15. Review of the progress note revealed the following medications listed to be administered post-operatively: 1. Timolol 0.5% 1 drop to left eye every day 2. Prolensa 0.07% 1 drop every day as directed in the operative eye after surgery	F 281	physicians with the residents' personal facility physician. All orders are being copied by Medical Records. All orders are being audited by the RN Supervisor/ Clinical Coordinators Monday-Friday with weekend orders being checked on Monday. The audits includes checking the order to the transcription onto the MAR for accuracy. The DON or RN Supervisor/Clinical Coordinator are reviewing all orders in the morning clinical meeting Monday-Friday. The DON or RN Supervisor/Clinical Coordinator will report the results of the audits to the QAPI committee on a monthly basis for 3 months.	

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F 281	Continued From page 28 3. Prednisolone Acetate 1% 1 drop three times a day as directed in the operative eye after surgery 4. Besivance 0.6% 1 drop three times a day in left eye - discontinue 03/13/15. An interview on 03/28/15 at 7:40 PM with the Director of Nursing (DON) revealed Resident #78's medical record should have included physician's orders for eye drops to the left eye that clarified the medications listed on the progress note. The DON stated the ophthalmologist always sent a list of medications with specific instructions for administration and she expected the nurse who received the medication list to write the medications on a telephone order and enter it on the resident's MAR.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer medication and obtain lab work as ordered by the physician for 2 of 5 sampled residents with medications reviewed. (Resident #47 and #60)	F 309	The facility will provide the necessary care and services to attain or maintain the hightest practicable physical, mental, and psychosocial well-being in accordance with their comprehensive assessment and plan of care.	4/17/15

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F 309	Continued From page 29 The findings included: 1. Resident #47 was admitted to the facility 12/18/13 and readmitted 02/05/15 with diagnoses which included gastrostomy, paralysis, acute respiratory failure, history of traumatic brain injury, late effect hemiplegia, depression and hypertension. Review of physician progress notes in the medical record of Resident #47 noted a progress note dated 02/23/15 which included, "Patient had a Complete Blood Count (CBC) done which revealed hemoglobin 10, hematocrit 29.4 with no history of anemia, melena, no abdominal pain or hematemesis." The diagnosis and assessment noted by the physician included, "Anemia, unspecified-get stool for hemocult, total iron level and start protein pump inhibitor. If iron deficiency, will need iron added. Will await blood work and if not iron deficiency, get B12 and Folate." An order was written by the physician on 02/23/15 for CBC, Basic Metabolic Package (BMP), total iron. A review of lab results in the medical record of Resident #47 noted on 02/25/15 the results of the CBC, BMP and total iron. Handwritten on the lab results was a note by the physician dated 03/02/15 to, "Start Ferrous Sulfate 325 twice a day for 2 months then discontinue. Recheck CBC." Review of March 2015 physician orders and the March 2015 Medication Administration Record (MAR) for Resident #47 noted a physician order had not been written for the Ferrous Sulfate or the lab work.	F 309	Resident #47 The Ferrous Sulfate was started on 3/27/2015 and ordered received to draw CBC on 3/30/2015. The lab results were received on 3/30/2015 and called to physician with no new orders. Resident #60 had a TSH drawn on 3/30/2015 and no new orders for this resident because it fell within normal range. The DON re-eduated the RN Supervisors/Clinical Coordinators verbally on their responsibility for verifying that all labs are checked daily and been drawn. They were also re-educated on notification of the physician, resident, responsible/interested parties, RN Supervisor/Clinical Coordinators will be doing rounds with physicians. All orders will be written on order sheets and flagged for nursing staff to identify that an order has been written. The RN Supervisor/Clinical Coordinator will review orders 3-5 times per week to ensure that all orders were transcribed correctly. The audit sheet and copies of the MD orders will be brought to the DON with the RN Supervisor/Clinical Coordinator initals verifying that all orders have been transcribed to the MARS or TARS accurately. All lab orders received by a physician must be placed on the the log in the Lab Log Book. Lab sheets will be completed	

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F 309	Continued From page 30 On 03/27/15 at 10:50 AM Nurse #1 stated when lab results were received, unless it was critical, one copy was placed in the residents chart and another copy in the physician's book. Nurse #1 stated a staff nurse made rounds with the doctor and, if orders were written on a residents lab results, it was the responsibility of the nurse making rounds to write the physician's orders. Nurse #1 relayed that in February there was another nurse making rounds with the physician but that nurse was no longer working at the facility. Nurse #1 reviewed the physician orders written on the lab work of Resident #47 as well as the March 2015 physician orders and MAR and stated the order for Ferrous Sulfate and repeat lab work was missed. On 03/28/15 at 7:00 PM the administrator stated the nurse that was doing rounds with the physician in February should have processed the order from the lab work of Resident #47 but failed to do so. The administrator stated the nurse that was doing rounds no longer worked at the facility and was not available to be interviewed. The administrator stated an order should have been written for the Ferrous Sulfate and repeat lab work and could not explain what happened. On 03/28/15 at 7:05 PM the Director of Nursing (DON) stated the staff member that was making rounds with the physician in February recently terminated employment with the facility and wasn't available for interview. The DON stated the order for Ferrous Sulfate and repeat lab work should have been written and could not explain what happened. The DON stated after she became aware of the omission, the physician was notified and orders were written for Ferrous Sulfate and the repeat lab work for Resident #47.	F 309	and placed under the date tag when due. The RN Supervisor/Clinical Coordinator will receive a copy of all orders and will verify that lab slips were filled out and log sheet was filled out in the lab book. A daily audit sheet is in each lab book for each day. The audit sheet will be brought to the clinical meeting Monday-Friday and reviewed by the DON or RN Supervisor/Clinical Coordinator and Administrator. All weekend orders will be audited and the copies of the orders and the audit will be brought to the DON for review on Monday. The RN Supervisor/Clinical Coordinator will report results of the audits to the QAPI committee for a period of 3 months.	

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2. Resident #60 was admitted to the facility on 11/19/12 with diagnoses which included: diabetes mellitus type II, hypertension, mood disorder and debility. A quarterly Minimum Data Set (MDS) assessment indicated Resident #60 had moderately impaired cognitive skills for daily decision making.

Review of Resident #60's medical record revealed a physician's progress note dated 03/18/15 which indicated Resident #60 was being seen at the request of nursing staff because he had been gradually declining, looked frail and debilitated and was requiring increased help with activities of daily living.

Review of Resident #60's physician's orders revealed an order dated 03/18/15 to obtain the following laboratory tests: complete blood count (CBC), comprehensive metabolic panel (CMP), Depakote level and thyroid stimulating hormone (TSH) level.

Review of Resident #60's medical record for lab results revealed results dated 03/20/15 for a CBC, CMP and Depakote level but not a TSH level.

An interview with the Director of Nursing (DON) on 03/28/15 at 7:23 PM revealed the facility's process for obtaining labs was for the nurse receiving the order for the lab test to write it in the lab book with the date it was to be done. The nurse working the 11:00 PM to 7:00 AM shift on the night before the lab was scheduled was responsible for completing a lab requisition form.

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F 309	Continued From page 32 The DON stated the facility had a contract with an outside laboratory provider who came to the facility between 5:00 AM and 7:00 AM every morning to draw any labs that were ordered. The DON stated either she or the Quality Assurance (QA) nurse compared the lab requisition forms with the lab book every day to verify that all ordered labs were obtained. The DON stated either she or the QA nurse also compared the lab results as they came in with the lab book. The DON stated the QA nurse should have discovered the TSH level wasn't done when she compared the lab requisition forms with the lab book on 03/18/15 or when the other labs came back on 03/20/15.	F 309		
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 observation, record review and staff interview, the facility failed to trim fingernails for 1 of 4 residents reviewed for activities of daily living (ADL). (Resident #5). The findings included: Resident #5 was admitted to the facility on 10/19/99 with diagnoses including hemiplegia, joint contracture of the hands, aphasia, and dementia without behavior disturbance. The most recent Minimum Data Set (MDS) dated	F 312	All residents that are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Resident #5 nails have been trimmed and filed and the nails are not jagged. The DON and RN Supervisor/Clinical Coordinator re-educated nursing staff	4/17/15

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F 312	Continued From page 33 03/05/15 indicated Resident #5 was cognitively intact with no mood or behavior problems, unclear speech, sometimes understood and usually understands. The MDS specified the resident required extensive assistance with staff assist of 1 for personal hygiene. A care plan for ADL dated 12/26/12 and reviewed 03/15/15 indicated Resident #5 required AM/PM care at least every morning and evening and the care recorded as completed, and with bathing to include full body skin checks and record findings. Review of a shower schedule revealed Resident #5 had showers scheduled Tuesdays and Fridays on first shift that showed what personal hygiene care should be completed such as hair washed, nails trimmed, teeth brushed, etc. Review of the shower sheet dated 03/03/15 revealed resident #5 had his hair washed with no documentation his nails had been trimmed. No other shower sheets were available for this resident for the rest of the month of March. An observation on 03/25/15 at 1:00 PM revealed Resident #5's fingernails on both hands extended approximately ¼ inch beyond the end of the finger tips and the left thumb nail was jagged and rested slightly on the left index finger. Continued observations on 03/26/15 at 8:45 AM and on 03/27/15 at 8:25 AM and 6:16 PM revealed Resident #5's fingernails on both hands remained long beyond the end of the resident's finger tips with a jagged left thumb nail. On 03/27/15 at 6:00 PM Nurse Aide (NA) #2, who worked 2nd shift on the hall Resident #5 resided on, was observed providing feeding assistance to him at the supper meal. She was interviewed after Resident #5 finished eating about ADL care. NA # 2 stated nurse aides do showers because there was no shower team. She stated residents receive 2 showers a week on Monday and	F 312	from March 30, 2015 to April 15, 2015 on ADL care which included nails being trimmed and cleaned at the time ADL's are done. The RN Supervisor/Clinical Coordinator is auditing nails for each resident 1-2 times per week and if nails need to be trimmed the nurse,RN Supervisor/Clinical Coordinator or C.N.A will trim the nails and clean them at that time. The DON or RN Supervisor/Clinical Coordintor will review the audit sheets at morning clinical meeting for compliance Monday-Friday. The results of the audit are reviewed with the Administrator 1 time per week. The DON will report the results of the audit to the QAPI committee on a monthly basis for a period of 3 months.	

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F 312	Continued From page 34 Thursday, Tuesday and Friday, and Wednesday and Saturday. She said if residents request more showers they can receive more showers. During the shower NA #2 said nurse aides are supposed to check residents skin for any skin conditions, if nails need trimmed (toe nails and finger nails), shaves need done and hair washed. NA #2 revealed nurse aides report any problems to the nurse and the nurse will check the resident in the shower room and treat the problem. NA # 2 stated the nurse signs the shower sheet when completed. NA # 2 was shown Resident #5's nails and she said she had not noticed his nails were long while providing feeding assistance and he should have had them trimmed. On 03/27/15 at 6:16 PM the Director of Nursing (DON) was shown Resident #5's fingernails and noted they were long and the left thumb nail was jagged. In an interview with the DON at this time she revealed she expected Resident #5's nails should have been trimmed.	F 312		
F 323 SS=K	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 review, and resident and staff interviews, the facility failed to implement and enforce smoking rules for 13 of 17	F 323	The facility will ensure that the resident environment remains as free as possible of accident hazards and each resident	4/17/15

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sampled residents. Three of the 13 residents (Residents #86, #96 and #133) were allowed to retain smoking material in their room after staff discovered them smoking within the facility. (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126, #129, #131, #132, #133).

Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/15 at 7:45 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 E (a pattern, 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 related to resident smoking.

The findings included:

The facility Smoking Policy (provided by the administrator on 03/25/15 from the facility admission packet) with revisions dated 01/01/13 and 01/08/15 included the following:
-The facility Administrator/Maintenance Supervisor have evaluated the facility and designated an appropriate area as the designated smoking area.
-All residents that desire to smoke will be assessed upon admission, quarterly, and PRN (as needed), for level of safety awareness to receives adequate supervsion and assistive devices to prevent accidents.

On March 26, 2015 the Interdisciplinary Team developed a new smoking policy which includes a safe smoking policy, unsafe smoking policy, staff responsibility and a Safe Smoking Data Collection Tool.

Facility staff were educated on the smoking policy from 3/26/2015 to 3/28/2015 and no staff was allowed to work until they had been educated on the policy. The smoking policy has been added to the orientation process which is done by the Staff Development Coordinator.

The smoking guidelines clearly state that the designated smoking area is in the front courtyard of the building and the staff monitors it on a regular basis to ensure residents are only smoking in the designated area.

The Administrator and Admission Director added the new smoking policy to the admission packet as an addendum. The resident, responsible party are required to sign the smoking policy stating that they understand the policy and agree to abide by the policy. A resident or responsible party that does not agree to abide by the policy will not be admitted to the facility.

Residents being admitted to the facility will give their cigarettes and lighters to the Admissions person or Charge Nurse until their "safe smoker data collection tool"

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F 323	Continued From page 36 determine if the resident is responsible, and what restrictions, if any, will need to be placed on the resident's smoking privileges. -The facility interdisciplinary team will then make the determination as to the above. -Based upon the smoking assessment, the resident may be required to wear a smoking apron and the resident care plan will be updated. -Any resident who has been assessed as unsafe will not be permitted to smoke without the direct supervision of a responsible staff member, visitor, or volunteer. Direct supervision must be provided throughout the entire smoking period. -The facility will provide direct supervision to those residents assessed as unsafe and wishing to smoke. -Smoking shall not be allowed inside the facility at any time. -Information regarding smoking privileges, including restrictions, will be documented in the resident's care plan. -Residents who have been assessed as being safe and responsible to smoke independently shall be provided their cigarettes, pipes, and tobacco by the smoking aide. -Lighter fluids, butane gas, any other forms of gas or fluids and matches will not be retained by the resident at any time. -Residents assessed as unsafe and non-responsible will not be permitted to retain any type of smoking equipment in his/her personal possession or living area. All smoking equipment for those residents will be left with the smoking aides. -The facility may make periodic checks to determine if residents who smoke have any smoking equipment that violates the facility's smoking regulations. If the facility has suspicion that a resident that is deemed unsafe and	F 323	has been completed and evaluated and signed by the Interdisciplinary Team. The cigarettes and lighting materials will marked with the resident name by the charge nurse or staff member receiving the smoking materials. The Director of Social Services will make the resident aware of the designation as "safe" or "unsafe". The resident or responsible party will sign the correct smoking policy including if they are deemed "safe" or "unsafe". A safe smoker will be allowed to keep their cigarettes in their room and they are not required to lock them up. There are to be no lighters in any resident room. The Administrator is auditing new admission packets 2-5 times per week to ensure that the policy is in the file and signed by the resident or responsible party. The results of the audits will be brought to the QA/QAPI committee on a monthly basis for a period of 3 months. No resident that has portable oxygen tanks are allowed in the designated smoking area. The portable tank or hold will have a "no smoking, oxygen in use" sign attached to the bag, tank or wheelchair. The Administrator and Smoking Supervisors are monitoring the designated smoking area to ensure that no residents are in the designated smoking area with portable oxygen tanks. A resident that comes to the designated smoking area with oxygen is immediately	

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F 323	Continued From page 37 non-responsible may have smoking equipment in their possession. These checks will be conducted by two staff members, and the resident/responsible party will be notified and given the opportunity to be present. -If any such equipment is found, staff will explain to the resident why the articles must be removed. The equipment will then be given to the charge nurse to store. -Admissions Coordinator/Social Services Director/designee will review the Resident Smoking Policy with the resident/responsible party prior to or upon admission and as needed thereafter on an individual basis. -The Director of Nursing Services/Designee will provide inservice training regarding the Resident Smoking policy to the facility staff during orientation, annually and as needed. On 03/25/15 a separate smoking policy was provided by the administrator. During an interview on 03/25/15 at 6:39 PM the administrator stated the second policy came from a new policy book provided to administration by the corporate office December of 2014. The administrator stated she was not aware there were two separate smoking policies, the specifics of the policies or that the two policies contradicted each other. The second policy from the December 2014 policy book included the following: -Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences; for example, in making room assignments. -Smoking restrictions shall be strictly enforced in all nonsmoking areas.	F 323	removed from the area,and the Administrator and DON are notified. The resident is put on q15 minute checks and the resident is educated on the hazards of going into a smoking area with oxygen. The weekend managers are required to complete the supervised smoking audit tool for each supervised smoking session they are monitoring on the weekend. Any concerns or problems experienced by the weekend smoking supervisors must be called to the Adminsitrator and DON.The weekend manager report is turned into the Administrator on Monday mornings for review in the morning department manager meeting. The resident audit tool is being completed for a period of 4 weeks with two additional questions and 2 additional observations. The answer of "yes" to any of the questions must immediately report that to the Administrator and Director of Nursing for immediate follow up. The questions are as follows: 1) do you smoke, 2) have you ever smoked, and if so how long ago. Those residents identified as smoking a month ago or less will have the "safe smoking data collection tool" completed regardless of whether they are currently smoking or not and the care plan will be updated according to our revised smoking policy. The additional observations as part of the resident audit are as follows: 1) Do you see any smoking materials in the room, and 2) Do you see a lighter in the room.	

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F 323	Continued From page 38 -The staff shall consult with the attending physician and the Director of Nursing Services to determine any restrictions on a resident's smoking privileges. -Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. -The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. -Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. -The staff will review the status of a resident's smoking privileges periodically, and consult as needed with the Director of Nursing Services and the attending physician. -Smoking articles for residents with independent smoking privileges: a. Residents who have independent smoking privileges shall be permitted to keep cigarettes, pipes, tobacco or other smoking articles in their possession b. Residents may only keep disposable safety lighters. All other forms of lighters, including matches, shall be prohibited. c. Residents may not have or keep lighter fluids, including butane gas, or any other forms of gas or fluids, at any time. d. Residents with independent smoking privileges may not give smoking articles to other residents with restricted smoking privileges e. Smoking shall not be permitted in bed, at any time, except under direct supervision.	F 323	Department Managers are to report immediately to the Administrator or Director of Nursing a lighter or smoking materials that are not allowed to be in the room. The lighter will be removed from the room by the Department Manager immediately. The resident audit tool is completed 1x a week by an assigned department manager and the Adminstrator reviews them 1x per week and the results of the audit tools are discussed in the morning meeting. The cumulative results, patterns, concerns will be identified and corrective action implementation will be done by the Administrator on a weekly basis. Residents that violate the smoking policy are re-educated by The Director or Social Services, Director of Nursing or the Administrator and they will discuss the infraction with the resident and assure they have an understanding of the smoking policy. A second infraction by the resident will result in an immediate 5 day discharge notice with safe discharge planning being done by the Director of Social Services. If the rsident was considered a "safe smoker" and has two infractions that are resulting in the 5 day immediate discharge they will then be moved to "unsafe smoker" and will supervised during smoking until their discharge takes place to protect the other residents from potential harm. The Administrator and Director of Nursing will report the results of the following audits: resident audit tool, supervised	

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F 323	Continued From page 39 -Smoking articles for residents without independent smoking privileges: a. Residents without independent smoking privileges may not have or keep any types of smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. b. Smoking shall not be permitted in bed without direct supervision. c. Anyone who provides smoking supervision to residents shall be advised of any restrictions/concerns and the plan of care related to smoking. -This facility may check periodically to determine if residents have any smoking articles in violation of our smoking policies. Staff shall confiscate any such articles, and shall notify the charge nurse/unit manager that they have done so. 1. Resident #96 was admitted to the facility on 04/16/14 with diagnoses which included history of alcohol and tobacco abuse. The most recent Minimum Data Set (MDS) dated 01/21/15 assessed Resident #96 with no cognitive impairment. The Smoking Policy signed on admission by Resident #96 on 04/16/14 noted smoking material would not be kept in the resident's room. A "Safe Smoking Needs Assessment" was not available on the resident's medical record throughout his admission at the facility from 04/16/14 - 03/09/15. On 03/25/15 at 12:43 PM MDS Nurse #1 stated smoking assessments were completed on admission, quarterly and as needed. MDS Nurse # 1 checked the resident's closed medical record and electronic medical record on 03/26/15 at 10:35 AM and confirmed a	F 323	smoking audit, proper storage of smoking material audit, residents with infractions of the smoking policy audit, and admission packet review audits to the QA/QAPI committee on a monthly basis for a period of 3 months.	

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smoking assessment had not been done on Resident #96. MDS Nurse #1 did not know why a smoking assessment had not been done throughout his stay at the facility.

A care plan for Resident #96 dated 08/06/14 and last updated on 01/29/15 did not address the resident's smoking and/or smoking cessation. Summaries of Care Plan conferences completed on 10/29/14 and 01/28/15 both indicated Resident #96 smoked unsupervised. On 03/27/15 at 5:13 PM MDS Nurse #1 stated she could not explain why the care plan for Resident #96 did not address smoking.

Review of Resident #96's medical record revealed a nurse's note dated 02/05/15 at 7:00 AM as a late entry for 01/19/15 which indicated an order was received for oxygen at 2 liters per minute for shortness of breath on an as needed basis. A nurse's note dated 02/05/15 at 7:27 AM indicated a Nurse Aide (NA) noticed a smoke smell in the hallway and asked the nurse to help locate the source of the smell. The note indicated the nurse entered the room of Resident #96 and he admitted to smoking part of a cigarette and asked the nurse not to tell anyone because he didn't want to get in trouble. The nurse advised Resident #96 that smoking was absolutely not allowed inside the facility and the resident voiced understanding. A nurse's note dated 02/05/15 at 1:34 PM indicated the Social Worker (SW) was informed the resident had admitted to smoking in his room the previous night. The SW informed Resident #96 he would be moved out of his current room and placed on every 15 minute checks per the directive of the Administrator and Director of Nursing (DON). The note also indicated the SW would pursue placement to

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another facility per the directive of the Administrator. A nurse's note dated 03/09/15 at 10:34 AM indicated Resident #96 was discharged from the facility at 8:45 AM on 03/09/15.

Further review of Resident #96's medical record revealed documentation of 15 minute checks that began on 02/05/15 at 1:45 PM and continued through 02/08/15 at 11:45 PM. No other safety checks were documented until 02/12/15 at 12:00 AM which continued through 02/13/15 at 10:30 PM. Additional safety checks were documented on 02/14/15 at 7:00 AM through 12:00 PM.

Review of a facility document titled "Incident/Accident Report" dated 02/05/15 at 5:30 AM indicated NA notified the nurse that she smelled smoke. The nurse entered the resident's room and he admitted to smoking part of a cigarette. Resident #96 was assessed as alert and oriented X 3. The form indicated the physician was not notified of the incident.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 04/16/14 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated when they began employment with the company in 2014 residents were allowed to maintain smoking materials in their room. The DON and administrator stated they allowed residents to maintain smoking

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material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in resident rooms.

On 03/26/15 at 12:22 PM the DON stated as a result of the 02/05/15 incident, Resident #96 was moved to another room, placed on 15 minute checks and discharge plans were initiated. The DON could not explain why the 15 minute checks did not begin until 1:45 PM on 02/05/15 (when the resident was found smoking at 7:27AM) and were not consistently performed on Resident #96 through the time of discharge on 03/09/15. The DON could offer no explanation why removal of smoking material from Resident #96 was not considered after the 02/05/15 incident.

On 03/27/15 at 11:42 AM Nurse #3, who remembered Resident #96, revealed he was regularly assigned to provide care to Resident #7 (the roommate of Resident #96 on 02/05/15) and

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Resident #96. Nurse #3 stated Resident #7 was on continuous oxygen 24 hours a day/7 days a week.

During an interview on 03/27/15 at 11:52 AM with Nurse #4 she stated she regularly provided care to Resident #7 and revealed he always wore his oxygen and she did not recall ever seeing him without oxygen in use.

An interview on 03/27/15 at 12:21 PM with the Staff Development Coordinator (SDC) revealed she worked from 11:00 PM on 02/04/15 until 7:00 AM on 02/05/15. The SDC stated she was notified by a NA that she smelled smoke so she went to investigate and determine the location of the smoke smell. The SDC stated she determined the smell was coming from the room of Resident #96. She stated when she entered his room he was lying in bed and was not wearing his oxygen. The SDC stated she didn't observe a cigarette in his hand or on his bed and did not check the bathroom. She stated she assumed he put the cigarette out in the toilet but didn't know that for sure. The SDC stated she recalled that his roommate, Resident #7, was in bed with oxygen in use at the time of the incident. The SDC stated she did not remove the cigarettes or lighter from Resident #7 but she informed the DON of the incident and was told to fill out the incident report.

In a follow-up interview on 03/27/15 at 6:00 PM MDS Nurse #1 stated removal of smoking material from Resident #96 after the the 02/05/15 incident was not considered because he was assessed a safe smoker because he was cognitively intact, could light and extinguish a cigarette and not drop ashes on himself. MDS

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Nurse #1 stated as long as a resident was assessed safe to smoke they were allowed to retain their smoking material in their room.
On 03/27/15 at 6:27 PM the SW stated she spoke with the administrator after the 02/05/15 smoking incident involving Resident #96. The SW stated the decision was made to initiate 15 minute checks and pursue discharge. The SW stated Resident #96 was moved from the room he was in because his roommate (Resident #7) was on continuous oxygen. The SW stated staff had not discussed removing smoking material from Resident #96 so he retained smoking material in his room through discharge on 03/09/15.

On 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.

2. Resident #126 was admitted to the facility on 03/03/15 with diagnoses which included chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated 03/10/15 assessed Resident #126 with no cognitive impairment and indicated Resident #126 used tobacco.

A "Safe Smoking Needs Assessment" completed on 03/03/15 did not indicate any needs or issues with Resident #126 related to smoking.

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The Smoking Policy signed on admission by Resident #126 on 03/03/15 noted smoking material would not be kept in the resident's room.

A care plan for Resident #126 dated 03/14/15 included a problem area that stated: "I am safe while smoking." Approaches to this problem area included: Educate my visitors about the smoking policy, Complete a Safe Smoking Assessment to identify my safety needs while smoking, Ensure that I/my responsible party understand the facility Smoking Policy.

On 03/25/15 at 11:35 AM Resident #126 was observed coming in from the facility's designated resident smoking area and was not observed with cigarettes, matches or a lighter.

On 03/25/15 at 11:44 AM an interview with Resident #126 in her room revealed she kept her cigarettes and lighter in an unlocked drawer in her nightstand. Resident #126 opened the drawer of the nightstand and showed the surveyor her cigarettes and lighter. The roommate of Resident #126 was observed with continuous oxygen in use via nasal cannula which was attached to an oxygen concentrator.

On 03/25/15 at 2:40 PM Resident #126 was observed outside, smoking independently in the area designated for smoking.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/03/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new

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management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated when they began employment with the company in 2014 residents were allowed to maintain smoking materials in their room. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in resident rooms. In a follow-up interview on 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident

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room that was not securely stored it should be secured.

3. Resident #73 was admitted to the facility on 02/24/15 with diagnoses which included chronic obstructive pulmonary disease and depressive. An admission Minimum Data Set (MDS) assessment dated 03/03/15 assessed Resident #73 with no cognitive impairment. The MDS indicated Resident #73 used oxygen.

A "Safe Smoking Needs Assessment" completed on 02/25/15 did not indicate any needs or issues with Resident #73 related to smoking.

The Smoking Policy signed on admission by Resident #73 on 02/24/15 noted smoking material would not be kept in the resident's room.

Review of Resident #73's physician's orders revealed an order dated 02/24/15 for oxygen at 1 to 5 liters per minute to keep oxygen saturation levels above 90%.

A care plan for Resident #73 dated 03/08/15 included a problem area that stated: "Resident is at risk for injury related to smoking activity due to potential for seizure." Approaches to this problem area included: Resident must smoke in designated areas only, during designated times, Resident to utilize smoking apron while smoking per facility policy, Staff to physically assist resident with smoking activity as needed, Monitor smoking habits and behaviors for poor safety and report, document and assess.

On 03/25/15 at 10:05 AM Resident #73 was observed sitting outside in the designated smoking area with other residents. Resident #73

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was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents.

During an interview with Resident #73 on 03/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she had been assessed as safe for smoking and didn't need to wear a smoking apron.

On 03/25/15 at 11:40 AM Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated: "We have a lot of people who wander and I figure if they can't see them they won't bother them." An oxygen concentrator with nasal cannula attached was observed beside the bed and Resident # 73 stated she used it all the time except when she went outside to smoke and she was getting ready to go outside to smoke.

An interview with Nurse #5 on 03/25/15 at 5:15 PM revealed she was regularly assigned to provide care for Resident #73. Nurse #5 stated Resident #73 used the oxygen continuously when she was in her room and the only time she left the room was to go smoke.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/24/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed

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by residents on admission. The DON and administrator stated when they began employment with the company in 2014 residents were allowed to maintain smoking materials in their room. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. The DON stated there was not a staff member present to monitor residents assessed as safe smokers to ensure a smoking apron was in place when the resident was smoking. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in resident rooms. In a follow-up interview on 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident

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room that was not securely stored it should be secured.

On 03/26/15 at 9:09 AM Resident #73 was observed sitting in her room with oxygen in use via nasal cannula.

On 03/26/15 at 9:55 AM Resident #73 was observed sitting outside in the facility's designated resident smoking area with other residents and a staff member, who was providing supervision. Resident #73 had a lit cigarette in her hand.

On 03/27/15 at 6:30 PM MDS Nurse #1 stated she was unaware the care plan for Resident #73 included an intervention for a smoking apron and was unclear if the smoking apron was indicated.

4. Resident #86 was admitted to the facility on 06/21/14 with diagnoses including tobacco use. Record review revealed a physician's order dated 06/25/14 for oxygen as needed (PRN) for shortness of breath and wheezing.
The Smoking Policy signed on admission by Resident #86 on 06/21/14 noted smoking material would not be kept in the resident's room.
The most recent Minimum Data Set (MDS)dated 03/23/15 coded Resident #86 as cognitively intact with no mood or behavior problems and that he used tobacco.
A care plan dated 10/19/14 identified a problem of Resident #86 apt to smoke cigarettes in unauthorized areas secondary to disorientation and complaints from other residents, staff and visitors. This care plan was updated on 01/07/15 to continue the problem and again on 02/16/15 it was updated because Resident #86 had smoked

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in the building. Approaches included to allow Resident #86 to smoke in designated areas only with verbal reminders for him to put on a smoking apron.
Review of a "Safe Smoking Needs Assessment" for Resident #86 dated 06/30/14 revealed no concerns identified regarding safe smoking.
Review of another "Safe Smoking Needs Assessment" dated 03/11/15 for Resident #86 revealed he falls asleep easily during tasks or activities and an intervention indicated he required application of a smoking apron. On 03/25/15 another "Safe Smoking Needs Assessment" was completed and revealed Resident #86 had dropped ashes on himself and the intervention indicated he continued to require a smoking apron.
Record review of a nurse's note dated 02/16/15 indicated that at approximately 3:30 AM the nurse noticed a smell of cigarette smoke in the hallway, near the nurse's desk, and the nurse walked in and out of rooms where she was working on the upper 100 hall and no smoke was noted. The nurse checked the activity dining room and found Resident #86 leaned back in his wheel chair with his eyes closed at the door going out to the smoke area. The nurse stated to the resident that he should lie down to rest because he had an Ambien (a medication for insomnia) and the resident told her he would lie down after he smoked. According to the note, as Resident #86 propelled himself out the door to smoke a cigarette was observed burned down to the butt (with ash attached) on the floor where the resident had been sitting. The nurse showed the resident the cigarette and the resident denied it was his cigarette. The nurse noted Resident #86 was the only person in the activity room at the time and he was placed on 15 minute checks and

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the Director of Nursing (DON) was called and informed of the incident.
On 03/25/15 at 9:54 AM Resident #86 was observed seated in his wheel chair in his room. The resident said he was going out to smoke. Observation of his over bed table revealed a plastic bag of loose tobacco with a machine for rolling cigarettes. Resident #86 stated he rolled his own cigarettes and kept the tobacco and lighter in his room. He said when he goes out to smoke he wears an apron. He was asked if he had ever smoked in the facility, either in the bathroom or some other part of the facility. The resident stated he had lit up a cigarette inside the facility in February before he went out to the courtyard to smoke because it was cold. He reported after the 02/16/15 incident he was told by the administrator he could not smoke in the facility because of fire laws. Resident #86 stated he was able to keep his rolling machine, tobacco and lighter in his possession.
On 03/25/15 at 10:05 AM Resident #86 was observed seated in his wheel chair out in the courtyard smoking with a smoking apron on.
On 03/25/15 at 12:43 PM MDS Nurse #1 stated staff who assess residents to smoke go outside and watch residents and determine if they are a safe smoker based on a residents ability to light their cigarette, extinguish their cigarette and if they dropped ashes on themselves when smoking. MDS Nurse #1 stated assessments are done on admission, quarterly and done again if there had been any change in the resident's mental status, medication changes, reports of physical changes and unsafe behaviors affecting resident's ability to smoke.
On 03/25/15 at 1:23 PM Resident #86 was observed to go out to the courtyard to smoke. When he arrived at the table to smoke he was

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observed to pick up a smoking apron lying on the back of the chair next to him and put it on with the material side out and not the shiny retardant material out. Observation revealed no staff directly supervising the smokers or available to assist Resident #86 to put the smoking apron on with the retardant side out.

On 03/25/15 at 6:14 PM Resident #86 was observed coming down the hall from smoking outside to return to his room. He was asked if he had his smoking materials with him and he answered yes and showed his empty pack of cigarettes and lighter. He stated that his cigarette pack was empty because he needed to roll more cigarettes.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 06/21/14 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered

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a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.
On 03/25/15 at 7:14 PM in a follow-up interview, MDS Nurse #1 stated Resident #86 required supervision while smoking to make sure he had his smoking apron on. MDS Nurse #1 stated Resident #86 had his own personal apron and that she was not aware of any instances of Resident #86 not putting his apron on correctly. MDS Nurse #1 stated Resident #86 was allowed to retain smoking material in his room (after 02/16/15) because he was considered a safe smoker due to the fact he could light his cigarette, extinguish his cigarette and wore a smoking apron to contain any dropped ashes. MDS Nurse #1 stated as long as a resident was assessed safe to smoke they were allowed to retain their smoking material in their room.
On 03/26/15 at 10:45 AM Resident #86's loose tobacco was observed stored in a plastic bag, in a box, and his rolling machine was observed on the over bed table with tobacco spilled out on the table from the machine. The bedside dresser did not have a locking drawer and Resident #86 stated he had not asked for a lock for the drawer.
An interview was conducted on 03/26/15 at 3:34 PM with Nurse #7 who had observed the incident on 02/16/15. Nurse #7, who had worked the night shift on 02/16/15, revealed she had smelled smoke in the hall in front of the nurse's desk. The nurse stated she walked down the hall to find out where the smoke was coming from and

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entered the activity dining room and found Resident #86 sitting in front of the door going out to the courtyard where residents smoke. The nurse said she observed a cigarette with ashes attached in front of resident #86's wheel chair on the floor. Nurse #7 reported she had asked the resident if he had smoked and he denied smoking. The nurse told the resident that a nurse aide had reported he had smoked and she said the resident did not admit it. Nurse #7 revealed she called the on call nurse and the DON. The DON placed Resident #86 on 15 minute checks and Nurse #7 did not recall how long he remained on 15 minute checks. Nurse #7 stated the Administrator came into the facility and she told the Administrator about the smoking incident and that was all she did. Nurse #7 said Resident #86 knew, and was told again, he was not to smoke in the building because it was not safe for other residents and himself. Nurse #7 stated that to her knowledge she was not aware of any other smoking incident with Resident #86 and he had kept his loose tobacco and tobacco rolling machine and lighter with him in his room.
Record review revealed 15 minute check sheets dated 02/16/15 and 02/17/15 were initiated to observe Resident #86 outside and inside the facility for any further smoking violations. He had no further smoking violations.
On 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be

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secured. The DON could offer no explanation why 15 minute checks were only done for 2 days or why consideration was not given to remove smoking materials from the room of Resident #86 after he was found smoking in the facility on 02/16/15.

5. Resident #131 was admitted to the facility on 03/13/15 with diagnoses including quadriplegia, visually impaired and tobacco use.

The smoking policy signed on admission by Resident #131 on 03/13/15 noted smoking material would not be kept in the resident's room.

The most recent Minimum Data Set (MDS) dated 03/20/15 coded Resident #131 as cognitively intact with no mood or behavior problems and that he used tobacco. His roommate had an order dated 06/25/14 for continuous oxygen at 3 liters per minute per nasal cannula for diagnoses of chronic obstructive pulmonary disease.

The care plan dated 03/22/15 identified a problem of Resident #131 at risk for injury related to smoking activity to include approaches that he must have direct supervision provided during the entire smoking period, monitor smoking habits and behaviors for poor safety and report, document and assess his ability to maintain safety during smoking, ensure he smokes in designated areas only and wears a smoking apron and resident's smoking materials were to be maintained by facility staff at all times.

Review of a "Safe Smoking Needs Assessment" for Resident #131 dated 03/25/15 noted resident with total or limited range of motion in arms and hands, diminished fine motor skills needed to hold a cigarette, drops ashes on self and unable to use ashtray to extinguish cigarette. The assessment noted Resident #131 required use of a smoking apron and for staff to extinguish his cigarette.

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On 03/25/15 at 11:05 AM Resident #131 was observed being assisted by staff out to resident designated smoking area. Staff was observed to light Resident #131's cigarette, place the cigarette in his mouth, remove the cigarette from the Resident's mouth, flick the ashes in the ashtray, and place the cigarette back in Resident #131's mouth.

On 03/25/15 at 1:35 PM Resident #131 was observed seated in his wheel chair, in his room, waiting to be taken to a doctor's appointment. He was observed to have a pack of cigarettes lying on his lap with the lighter located in the cellophane cover of the cigarette pack. He stated he would put his cigarettes and lighter in his top drawer of his bedside table before he left for the doctor's appointment. Observations of Resident #131's bedside dresser revealed there was no lock on the drawer. An oxygen sign was on the outside of Resident #131's room and the roommate of Resident #131 was wearing a nasal cannula with oxygen being provided via an oxygen concentrator.

On 03/25/15 at 5:05 PM a cigarette pack and lighter were observed stored on the over bed table of Resident #131. Resident #131 had splints on both hands and his roommate was wearing a nasal cannula with oxygen being provided via an oxygen concentrator.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/13/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed

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by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.

On 03/25/15 at 7:30 PM an interview was conducted with the Admission Coordinator who had recently been hired. She stated she goes over the Smoking Policy with residents who smoke at the end of the admission process. She said all residents sign the Smoking Policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision.

On 03/27/15 at 5:13 PM an interview was conducted with MDS Nurse #1. She could not explain why Resident #131 would have cigarettes and lighter in his room noting he was a supervised smoker and it was inconsistent with what was in his care plan.

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On 03/28/15 at 12:21 PM an interview was conducted with the DON. She stated that residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking materials in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their night stand they needed to request a lock from the Maintenance Director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured. The DON had no explanation why smoking material was retained in the room of Resident #131.

6. Resident #23 was admitted to the facility on 09/01/03 with diagnoses including depression and history of tobacco use.

The Smoking Policy signed by Resident #23 on 04/29/13 noted smoking material would not be kept in the resident room.

The most recent Minimum Data Set (MDS) dated 03/02/15 assessed Resident #23 as cognitively intact with moderately impaired vision. His annual MDS dated 12/02/14 revealed he used tobacco.

Review of a "Safe Smoking Needs Assessment" dated 05/24/13 for Resident #23 revealed he had diminished fine motor skills, needed to securely hold his cigarette, he dropped ashes on himself and he must wear a smoking apron. Review of the "Safe Smoking Needs Assessment" form dated 03/25/15 revealed no problems.

A care plan dated 12/08/14 and updated on 03/02/15 identified a problem of Resident #23 at risk for injury related to cigarette smoking. Approaches included: supervision and use of a smoking apron, education on the danger/hazards of smoking, evaluate the resident for smoking

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level per policy to determine if he was a safe smoker or unsafe smoker.
On 03/25/15 at 1:06 PM Resident #23 was observed seated in his wheelchair in his room and he had a pack of cigarettes on his lap and was holding his lighter in his hand. Resident #23 stated he kept his cigarettes and lighter in the room because he was considered a safe smoker. Resident #23 also indicated he did not need a smoking apron.
On 03/25/15 at 1:22 PM Resident #23 was observed outside unsupervised in the smoking area. He was smoking and did not have a smoking apron on.
On 03/25/15 at 6:15 PM Resident #23 was observed coming down the hall from smoking outside in the designated area for residents to smoke. Resident #23 reported he had his smoking materials and lighter with him and was returning to his room.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on 04/29/13 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. The DON stated there was not a staff member present to monitor residents assessed as safe smokers to

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ensure a smoking apron was in place when the resident was smoking. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.

On 03/26/15 at 1:08 PM a follow-up interview was conducted with Minimum Data Set (MDS) Nurse #1. She stated Resident #23 was assessed as a safe smoker but must be supervised and wear an apron. MDS Nurse #1 revealed Resident #23 was a safe smoker because he could flick off his own ashes, light his own cigarette, take the cigarette out of the pack and put the cigarette to his mouth. MDS Nurse #1 stated some of Resident #23's clothes had holes and she did not know if the holes in his clothes were burns from cigarettes because there were no brown edges around the holes. MDS Nurse #1 stated Resident #23 was supposed to wear his apron and that staff supervising residents who smoked should know if a resident needed a smoking apron or not.

On 03/26/15 at 1:15 PM Resident #23 stated he had his own smoking apron to wear but would forget to bring it out with him when he went out to smoke.

On 03/28/15 at 12:21 PM an interview was

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conducted with the Director of Nursing (DON). She stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking materials in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their night stand they needed to request a lock from the Maintenance Director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.
7. Resident #36 was admitted to the facility on 12/11/07 and readmitted on 08/17/12 with diagnoses including chronic airway obstruction. The Smoking Policy signed by Resident #36 on 04/29/13 noted smoking material would not be kept in the resident room.

The most recent Minimum Data Set (MDS) dated 02/09/15 coded Resident #36 as cognitively intact with no mood or behavior problems and use of tobacco.
A care plan dated 11/24/14 and reviewed 02/24/15 identified a problem Resident #36 was at risk for injury related to cigarette smoking. Approaches included to allow Resident #36 to smoke in designated smoking areas only, to encourage her to wear a smoking apron during smoke breaks because she nods off while smoking and has a history of lighting other residents cigarettes. In addition, another approach included that Resident #36's cigarettes and lighter must be locked up on the smoking cart.
Review of the "Safe Smoking Needs Assessment" dated 03/25/15 for Resident #36 revealed no problems.
On 03/25/15 at 10:58 AM Resident #36 was observed seated in her wheel chair out in the

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courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking with no smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarettes and lighter in her locked dresser drawer in her room.
On 03/25/15 at 11:52 PM Resident #36 was observed going to her room after she had smoked. Resident #36 reported she kept her cigarette and lighter in a case on her wheelchair during waking hours. Resident #36 stated she locked her cigarette and lighter in the drawer on the bedside table at night.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on 04/29/13 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. The DON stated there was not a staff member present to monitor residents assessed as safe smokers to ensure a smoking apron was in place when the resident was smoking. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not

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drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.
On 03/27/15 at 5:13 PM a follow up interview was conducted with MDS Nurse #1. She stated she did not realize the care plan for Resident #36 included an approach for cigarette and lighter to be locked in the smoking cart and for a smoking apron.
On 03/28/15 at 12:21 PM an interview was conducted with the Director of Nursing (DON). She stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking materials in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their night stand they needed to request a lock from the Maintenance Director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.
8. Resident #133 was admitted to the facility on 03/05/15. Diagnoses included intestinal fistula and vertebral fracture.
A 5-Day Minimum Data Set dated 03/12/15 indicated Resident #133 was cognitively intact.
A review of the care plan for Resident #133 revealed an Interim Care Plan dated 03/05/15 which did not address smoking.
The Smoking Policy signed by Resident #133 on 03/05/15 noted smoking material would not be kept in the resident's room.

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A "Safe Smoking Needs Assessment" completed 03/06/15 documented no risk factors for smoking and no nursing interventions to be implemented related to smoking.
Review of Resident #133's medical record revealed a nurses note dated 03/06/15 at 3:59 PM and detailed as a late entry for 8:00 AM. The note read, Entered resident's room and noted strong odor of cigarette smoke. Nurse asked resident if he smoked in his room and resident confirmed that he had. Nurse asked resident if he knew this was against the rules of the facility and he denied knowing it was. Resident was educated on policy and the location of the smoking area and resident stated understanding.
A social work note dated 03/06/15 noted Resident #133 had been observed smoking a cigarette in the resident's room at 8:00 AM and subsequently being put on fifteen-minute checks. The social work note indicated Resident #133 stated he was unaware of the facility's smoking policy and would follow the policy moving forward.
A review of the fifteen-minute checks revealed Resident #133 was observed every fifteen minutes beginning on 03/06/15 at 6:00 PM and ending 03/08/15 at 2:30 PM.
Further review of the medical record revealed a social worker note dated 03/06/15. The note described the Social Worker speaking with Resident #133 about the rule against smoking in the building and the resident voiced understanding of the rule.
A nurse's note on 03/08/15 at 6:59 PM noted, At 12:30 PM Resident #133 signed himself out of the facility and returned at 2:00 PM. His breath smelled like he had been drinking, and his behavior was a little more erratic. At 3:50 PM he was on the telephone in his room and was somewhat agitated with the call. He lit a cigarette

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in his room. When nurse entered the room and stated, you cannot smoke in the room, he immediately extinguished the cigarette and apologized. The resident stated he was worried about some issues with his living situation and lit a cigarette without thinking.
Another social services note on 03/09/15 described the Social Worker speaking again with Resident #133 about smoking in the room. The Social Worker documented she discussed discharge with the resident due to failure to follow the rules about smoking in the facility.
A social services note dated 03/12/15 documented Resident #133 was discharged home.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/05/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered

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a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.
An interview was conducted with Nurse #1 on 03/26/15 at 10:12 AM. Nurse #1 was the nurse who observed Resident #133 smoking in his room on 03/06/15 and 03/08/15. She stated after she caught Resident #133 smoking in the room the first time, she informed the Director of Nursing and the Social Worker. She explained she placed the resident on fifteen-minute checks. She could not explain why the fifteen-minute checks were not started until 6:00 PM on 03/06/15 nor why the checks were not documented after 2:30 PM on 03/08/15. She however verified when she was on duty she had done the fifteen-minute checks after 2:30 PM on 03/08/15 and that was how she observed Resident #133 smoking at 3:50 PM.
An interview was conducted with the Director of Nursing (DON) on 03/26/15 at 10:29 AM. She explained she expected the fifteen-minute checks to be completed from the first moment Resident #133 smoked in the facility up until the resident was discharged from the facility. She could not explain why the fifteen-minute checks were not documented after 2:30 PM on 03/08/15 and could not provide any further documentation of fifteen-minute checks. She stated she was aware Resident #133 retained smoking materials in his room through discharge 03/12/15. The DON further verified she explained to the resident why he could not smoke in the building after the

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resident smoked in his room on 03/06/15, but she had concerns of the resident being able to fully understand the reason for not smoking inside the building.
An interview was conducted with MDS Nurse #1 on 03/27/15 at 5:13 PM. She stated residents who wished to smoke were observed smoking a cigarette, and they would be deemed safe if they could independently light, hold, and extinguish the cigarette without dropping ashes on themselves. MDS Nurse #1 stated Resident #133 was allowed to retain smoking material in his room (after 03/06/15 and 03/08/15) because he was considered a safe smoker due to the fact he could light his cigarette, extinguish his cigarette and not drop ashes on himself. MDS Nurse #1 stated as long as a resident was assessed safe to smoke they were allowed to retain their smoking material in their room. She could not explain why Resident #133's Interim Care Plan did not address a problem area of smoking or include interventions to address smoking.
On 03/28/15 at 12:21 PM an interview was conducted with the Director of Nursing (DON). She stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking materials in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their night stand they needed to request a lock from the Maintenance Director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.
9. Resident #44 was readmitted to the facility on 11/06/14. Diagnoses included chronic obstructive pulmonary disease, incomplete quadriplegia, and spinal cord injury.
An annual Minimum Data Set (MDS) dated

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10/10/14 indicated Resident #44 used tobacco. A quarterly MDS dated 01/09/15 indicated the resident was cognitively intact.
The Smoking Policy signed by Resident #44 on 11/07/14 noted smoking material would not be kept in the resident's room.
A review of the care plan revised 09/03/14 and 03/12/15 identified a problem area of Resident #44 wishing to smoke cigarettes. The goal was to keep the resident safe through the next review. Interventions included providing one-on-one supervision while smoking, nursing to keep cigarettes and lighter in a safe area, and to create a smoking schedule. The care plan did not identify a need for Resident #44 to wear a smoking apron.
A "Safe Smoking Needs Assessment" completed 01/21/15 indicated no risk factors for smoking and no nursing interventions related to smoking. The tool also indicated the need for Resident #44 to wear a smoking apron while smoking.
A physician's order dated 11/06/14 ordered Resident #44 to have supplemental oxygen at three liters per minute while in bed for shortness of breath.
Observation of Resident #44 on 03/25/15 at 11:43 AM revealed the resident was sleeping in his room. His oxygen concentrator was on and running. No smoking paraphernalia was observed to be immediately or easily accessible.
On 03/25/15 at 12:49 PM, Resident #44 was observed smoking outside in the designated smoking area. He was not wearing a smoking apron and was not being supervised by a staff member.
Resident #44 was interviewed on 03/25/15 at 12:49 PM. He stated he went outside to smoke whenever he wanted. He explained he kept his cigarettes and lighter in a small bag attached to

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the right side of his wheelchair seat. Observation of the bag revealed a pack of cigarettes and a lighter were clearly visible.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on 11/07/14 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.
On 03/26/15 at 9:38 AM Resident #44 stated the facility reviewed the smoking policy with him when he was admitted. He stated the designated

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smoking area was the courtyard. The resident further explained he was allowed to keep his cigarettes and lighter when he was admitted. During the interview, a pack of cigarettes and a lighter were observed in the small bag attached to his wheelchair seat.
An interview was conducted with MDS Nurse #1 on 03/27/15 at 5:13 PM. She stated the admitting nurses were responsible for completing the nursing admission assessments, including the Safe Smoking Needs Assessment. She stated residents who wished to smoke were observed smoking a cigarette, and they would be deemed safe if they could independently light, hold, and extinguish the cigarette without dropping ashes on themselves. MDS Nurse #1 explained she assumed the Admissions Coordinator told newly admitted residents their cigarettes and lighters had to be locked up. In a follow-up interview on 03/27/15 at 6:30 PM MDS Nurse #1 stated she could not explain why the current care plan for Resident #44 indicated, "nursing to keep cigarette and lighter in a safe place". MDS Nurse #1 stated staff supervising residents smoking should ensure a smoking apron was on place.
A follow-up interview was conducted with the DON on 03/28/15 at 12:21 PM. She stated she, the floor nurse, or the nurse Supervisor would make sure the resident knew not to smoke around oxygen concentrators; however, none of the staff discussed with residents where to store smoking paraphernalia. She stated she expected all lighters and cigarettes to be stored out of sight. She further explained a resident would have to notify the Maintenance Director if they wanted a lock to be placed on a nightstand.
10. Resident #91 was readmitted to the facility on 12/25/14. Diagnoses included hypertension and coronary atherosclerosis.

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An annual Minimum Data Set dated 03/17/15 indicated that Resident #91 used tobacco products and was cognitively intact.
The Smoking Policy signed by Resident #91 on 02/11/14 noted smoking material would not be kept in the resident's room.
A "Safe Smoking Needs Assessment" completed on 12/25/14 for Resident #91 documented no risk factors for smoking and no nursing interventions to be implemented related to smoking. A "Safe Smoking Needs Assessment" completed 03/25/15 for Resident #91 noted no risk factors related to smoking but indicated the need of Resident #91 to wear an apron and have a cigarette holder when smoking.
A review of Resident #91's care plan revised 03/25/15 revealed a problem area of smoking. The goal was to keep the resident safe through the next review. The interventions included the resident wear a smoking apron and to provide periodic supervision when resident refused to wear the smoking apron.
Observation of Resident #91 on 03/25/15 at 5:14 PM revealed the resident was outside smoking. He was not wearing a smoking apron. His smoking was being supervised by the Administrator, the Director of Nursing, and the Social Worker.
On 03/26/15 at 8:54 AM Resident #91 stated the facility reviewed the smoking policy with him when he was admitted. He explained he knew the only place for him to smoke was the courtyard. He further explained he could keep his cigarettes and lighter on him, and he kept them in his pocket.
On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on 02/11/14 included smoking

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material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. The DON stated there was not a staff member present to monitor residents assessed as safe smokers to ensure a smoking apron was in place when the resident was smoking. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.

An interview was conducted with MDS Nurse #1 on 03/27/15 at 5:13 PM. She stated the admitting nurses were responsible for completing the nursing admission assessments, including the Smoking Safety Needs Data Collection tool. She stated residents who wished to smoke were

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observed smoking a cigarette, and they would be deemed safe if they could independently light, hold, and extinguish the cigarette without dropping ashes on themselves. MDS Nurse #1 explained she assumed the Admissions Coordinator told newly admitted residents their cigarettes and lighters had to be locked up.
A follow-up interview was conducted with the DON on 03/28/15 at 12:21 PM. She stated she, the floor nurse, or the nurse Supervisor would make sure the resident knew not to smoke around oxygen concentrators; however, none of the staff discussed with residents where to store smoking paraphernalia. She stated she expected all lighters and cigarettes to be stored out of sight. She further explained she would notify the Maintenance Director when a resident requested a lock to be placed on a nightstand.
11. Resident #47 was admitted to the facility on 12/18/13 and readmitted 02/05/15 with diagnoses which included paralysis, acute respiratory failure, history of traumatic brain injury, late effect hemiplegia and depression. The current Minimum Data Set (MDS) dated 02/10/15 assessed Resident #47 with no cognitive impairment. The significant change MDS assessment completed 07/04/14 assessed Resident #47 with use of tobacco.

The Smoking Policy signed on admission by Resident #47 on 12/18/13 noted smoking material would not be kept in the resident room.

A "Safe Smoking Needs Assessment" completed on readmission 02/06/15 did not indicate any needs or issues with Resident #47 related to smoking. A "Safe Smoking Needs Assessment" dated 03/25/15 for Resident #47 noted issues with "balance problem while sitting or standing",

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"diminished fine motor skills needed to securely hold cigarette" and "drop ashes on self". Interventions to protect the resident from injury was to "apply smoking apron".

The care plans for Resident #47 included the following problem areas and approaches:
A problem area dated 09/16/14 and updated 02/25/15 noted, "I am safe while smoking". Approaches to this problem area included: Apply smoking apron while I am smoking, Complete a Safe Smoking Assessment to identify my safety needs while smoking and Ensure that I/my responsible party understand the facility Smoking Policy.
A problem area dated 12/21/13 and updated 03/24/15 noted, "Resident is exhibiting non-compliance behavior". A care plan dated 07/23/14 and updated 02/25/15 noted, "Resident has episodes of yelling, screaming and cursing: refusing/resisting care and following facility policies with periods of agitation/angry outbursts".

On 03/24/15 at 11:20 AM Resident #47 was observed outside, smoking independently in the area designated for smoking. At the time of the observation, Resident #47 stated he kept his cigarette and lighter in his room either in his pocket or in a locked bedside drawer. On 03/25/15 at 11:06 AM a lighter was observed on the dresser, in the room of Resident #47. The door of the room was open and the lighter was in eyesight on the dresser in the room. Resident #47 (private room) was not in the room at the time of the observation. A second observation on 03/25/15 at 11:32 AM noted the lighter had been removed from the dresser. On 3/27/15 at 8:25 PM Resident #47 stated he never left a lighter on his dresser and could not explain how a lighter

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would have been left on the dresser. Resident #47 indicated he always kept smoking material in his pocket or locked bedside drawer.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 12/18/13 included smoking material would not be kept in the resident room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated when they began employment with the company in 2014 residents were allowed to maintain smoking materials in their room. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a residents room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a

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system in place to monitor smoking material storage in resident rooms. In a follow-up interview on 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured. The DON stated she was not aware of any instances of Resident #47 leaving a lighter unattended in his room.

12. Resident # 129 was admitted to the facility on 03/22/15 with diagnoses of muscle weakness and difficulty in walking.

The Smoking Policy signed by Resident #129 on 03/22/15 noted smoking material would not be kept in the resident's room.

Review of the Minimum Data Set (MDS) 5 day Assessment dated 03/29/15 revealed cognitive skills for daily decision making: Modified independence-some difficulty in new situations only. Resident # 129 was identified for current tobacco use.

Review of an interim care plan dated 03/22/15 revealed smoking was not identified as a problem for Resident # 129.

Review of the "Safe Smoking Needs Assessment" 03/22/15 revealed Resident # 129 had no concerns identified regarding safe smoking.

On 3/25/15 at 10:58 AM an observation of Resident # 129 revealed she was outside,

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unsupervised smoking. Resident # 129's hands were shaking and she dropped ashes on her blouse. Resident # 129 was unaware of ashes on her blouse until pointed out by a surveyor.

On 03/25/15 at 11:40 AM an observation of Resident # 129 revealed she was outside smoking in the facility courtyard. Resident # 129 finished her cigarette and ambulated back to her room. She had her cigarettes and lighter in her hand, and sat down on the bed.

On 03/25/15 at 1:10 PM an observation of Resident # 129 revealed she was leaning back in her bed, with her eyes closed. Her cigarettes and lighter were on the over bed table.

On 03/25/15 at 6:30 PM an observation of Resident # 129 revealed she was sleeping on top of the bed linens, and a pack of cigarettes, and 2 lighters were on the bedside table.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/22/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for

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residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking material storage in a resident rooms.

On 03/25/15 at 7:30 PM an interview was conducted with the Admissions Coordinator. She stated she went over the smoking policy with any residents who smoke at the end of the admission process. She stated all residents sign the smoking policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision.

On 03/26/15 at 9:30 AM an interview was conducted with Resident # 129. She stated when she was admitted she was told she could keep her cigarettes and lighter with her. She also stated she was told she could smoke outside whenever she wanted. No locks were observed on any dresser in her room to secure smoking materials.

On 03/27/15 at 5:13 PM MDS Nurse #1 stated she knew the resident could go out to smoke in

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designated areas and that cigarettes and lighters could be kept in resident's room in the night stand in the locked drawer. MDS Nurse #1 revealed the admitting nurse was responsible for doing the smoking assessment. She stated the smoking assessment was not clear as to whether residents were safe or unsafe to smoke but the care plan was specific if a resident should be supervised or unsupervised when smoking. She said the care plan for smokers provided an approach for a resident to be supervised or unsupervised. MDS Nurse #1 reported the care plan was done immediately after the smoking assessment had been completed. She stated Resident # 129 was admitted on the weekend, and the nurse should have indicated whether she was safe or an unsafe smoker when she completed the smoking assessment, and put it on the initial care plan, under the falls and safety risk. She stated she had assumed that the admissions coordinator had told residents that smoking materials had to be locked up. She said she did not make sure residents had a lock on their bedside drawer and thought maintenance provided locks for resident's drawers.

On 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.

13. Resident # 132 was admitted to the facility on

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03/21/15 with diagnoses of chronic obstructive pulmonary disease, chronic back pain, and arm surgery.
Review of the Minimum Data Set (MDS) 5 day Assessment dated 03/28/15 revealed cognitive skills for daily decision making: Independent decisions consistent/reasonable. Resident # 132 was identified for current tobacco use.

The Smoking Policy signed by Resident #132 on 03/21/15 noted smoking material would not be kept in the resident's room.
Review of the "Safe Smoking Needs Assessment" dated 03/21/15 revealed Resident # 132 had no concerns identified regarding safe smoking.

Review of an interim care plan dated 03/22/15 revealed smoking was not identified as a problem for Resident # 132.

On 03/25/15 at 11:40 AM an observation of Resident # 132 revealed she was outside smoking in the facility courtyard. Resident # 132 finished her cigarette and propelled herself back to her room in a wheelchair. She had her cigarettes and lighter with her. Further observation revealed she had an oxygen concentrator in her room, and it was on.

On 03/25/15 at 1:16 PM an interview with Resident # 132 revealed she kept her cigarettes and lighter with her, and after she came back in from smoking, she hid them under her pillow.

On 03/25/15 at 6:25 PM an observation of Resident # 132 revealed she was in her room, in bed. Her oxygen concentrator was on, and she had a pack of cigarettes on her bed next to her.

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She also had a bag of unopened cigarettes in her hand. She was moving about in her bed and stated she could not find her lighter and was looking for her lighter in her bed. No locks were observed on her bedside dresser to secure smoking materials.

On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/21/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a resident was cognitively intact, could light and extinguish their cigarette independently and not drop ashes on themselves they were considered a safe smoker. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. The DON stated there was not a system in place to monitor smoking

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material storage in a resident rooms.
On 03/25/15 at 7:30 PM an interview was conducted with the Admissions Coordinator. She stated she went over the smoking policy with any residents who smoke at the end of the admission process. She stated all residents sign the smoking policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision.

On 03/26/15 at 9:15 AM Resident # 132 stated she had her cigarettes and lighter with her, and no one told her she could not have them. She further revealed she thought it was a nurse who told her she would be assessed for smoking safety and could smoke any time after the assessment, outside in the courtyard.

On 03/27/15 at 5:13 PM MDS Nurse #1 stated she knew residents could go out to smoke in designated areas and that cigarettes and lighters could be kept in resident's room in the night stand in the locked drawer. MDS Nurse #1 revealed the admitting nurse was responsible for doing the smoking assessment. She stated the smoking assessment was not clear as to whether some were safe or unsafe to smoke but the care plan was specific if a resident should be supervised or unsupervised when smoking. She said the care plan for smokers provided an approach for a resident to be supervised or unsupervised. MDS Nurse #1 reported the care plan was done immediately after the smoking assessment had been completed. MDS Nurse #1 stated Resident # 132 was admitted on the weekend, and the nurse should have indicated whether she was safe or an unsafe smoker when she completed

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the smoking assessment, and put it on the initial care plan. She stated she had assumed that the admissions coordinator had told residents that smoking materials had to be locked up. She said she did not make sure residents had a lock on their bedside drawer and thought maintenance provided locks for resident's drawers.

On 03/28/15 at 12:21 PM the DON stated residents that smoked were informed not to smoke around oxygen but, other than that, specifics of where to store smoking material in their room was not discussed. The DON stated if a resident wanted to lock their smoking material in their nightstand they needed to request a lock from the maintenance director. The DON stated if staff saw any smoking material in a resident room that was not securely stored it should be secured.

On 03/26/15 at 6:40 PM the administrator and DON were notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/28/15 at 11:59 AM.

Credible Allegation of Compliance

On March 26, 2015, the inter-disciplinary team developed a new smoking policy, the Safe Smoking policy, the Unsafe Smoking Policy, the Staff Smoking Responsibility and Safe Smoking Data Collection Form. The policy specified that smoking materials (cigarettes and lighters) will be kept in a plastic container on the 200 hall med room, however residents deemed to be "safe" smokers are allowed to keep cigarettes in their room. The Director of Admissions will review the safe and unsafe smoking policy during the admission process with residents and/or family

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members or RP. The Safe Smoking Data Collection form will be used on all new, existing and readmissions to the facility. The form will be completed by the admission Charge Nurse, and the information will be submitted to the facility interdisciplinary team to determine if resident is considered a safe or unsafe smoker. The resident upon admission will need to surrender their cigarettes and lighter until a determination is made if they are a safe or unsafe smoker. The resident will be considered unsafe until the inter-disciplinary team reviews the Safe Smoking Data Collection Form and make a decision. Residents will be informed of the decision regarding safe or unsafe smoking by the Director of Social Services. Further smoking assessments are conducted by the MDS Nurse quarterly, change of condition, and at the residents request.

Smoking for residents is to only take place in the designated area which is the front courtyard. If using portable oxygen on the wheelchair must be identified with a no smoking sign and cannot be out in the designated smoking area.

A.
Resident #1 (Resident #47 on the 2567)-Has been reassessed under the new smoking policy and is determined an "unsafe smoker". Lighters and cigarettes have been removed from this resident room. The care plan has been updated. The resident has signed the new smoking policy. On 3/27/15, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
03/27/2015

Resident #2 (Resident #86 on the 2567)-Has

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been reassessed under the new smoking policy and is determined an "unsafe smoker". Lighters and cigarettes have been removed from this room. The care plan has been updated. The resident has signed the new smoking policy. On 3/27/15, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
03/27/2015

Resident #3 (Resident #23 on the 2567)-Has been reassessed under the new smoking policy and is determined an "unsafe smoker". Lighters and cigarettes have been removed from this resident room. The care plan has been updated. The resident has signed the new smoking policy. On 3/27/15, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
03/27/2015

Resident #4 (Resident #73 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 3/27/15, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
03/27/2015

Resident #5 (Resident #126 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 3/27/2015, letters were sent to the family

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F 323	Continued From page 87 members and/or RP regarding the smoking policy by the Director of Social Services. 03/27/2015 Resident #6 (Resident #44 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 3/27/15, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services. 03/27/2015 Resident #7 (Resident #36 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 3/27/2015, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services. 03/27/2015 Resident #8 (Resident #132 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 03/27/2015, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services. 03/27/2015 Resident #9 (Resident #129 on the 2567)-Has been reassessed under the new smoking policy	F 323		

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and is determined an "unsafe smoker". Lighters and cigarettes have been removed from this resident room. The care plan has been updated. The resident has signed the new smoking policy. On 3/27/2015, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
3/27/2015

Resident #10 (Resident #131 on the 2567)-Has been reassessed under the new smoking policy and is determined an "unsafe smoker." Lighters and cigarettes have been removed from this resident room. The care plan has been updated. The resident has signed the new smoking policy. On 3/27/2015, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
3/27/2015

Resident #11 (Resident #91 on the 2567)-Has been reassessed under the new smoking policy and determined to be a "safe smoker". The lighter has been removed from the room. The resident care plan has been updated. The resident has signed the new smoking policy. On 3/27/2015, letters were sent to the family members and/or RP regarding the smoking policy by the Director of Social Services.
3/27/2015

Resident #12 (Resident #133 on the 2567)-Resident #12 was discharged from the facility on March 12, 2015.

Resident #13 (Resident #96 on the 2567)-Resident #13 was discharged from the facility on March 9, 2015.

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Nurse 1 and Nurse 2 were re-educated on recording and performing of the 15 minute checks by the Director of Nursing.
3/27/2015

New residents admissions and/or their family or RP are educated on the new smoking policy by the Director of Admissions. All current residents were educated on the new smoking policy by the Director of Social Services and have signed the "safe" or "unsafe" smoking policy depending on the outcome of their "Safe Smoking Data Collection Form".
3/27/2015

B.
The resident audit tool which gathers information on a weekly basis regarding staff professionalism, dignity, choice, preferences, ADL care, therapy services, has had the questions added "Do you smoke?". Every resident in the facility is interviewed every week by the Inter-Disciplinary team member designated to be their Resident Champion. The results on the interviews are reviewed by the Administrator and summarized for the inter-disciplinary team and areas of concern are addressed by the appropriate department. Those concerns that require immediate attention such as a resident indicating that they smoke would immediately be made known to the Director of Nursing or Administrator.
3/27/2015

The MDS staff reviewed comprehensive assessments for the last 30 days to identify any additional residents that smoke and were not addressed on the initial list. An audit was conducted on 3/26/2015 and 3/27/2015 by the interdisciplinary team in person to identify any

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other potential smokers that may not have been identified in previous audits.
3/27/2015

The new assessment tool developed on March 26, 2015 by the facility inter-disciplinary team added the following information:
Does the resident know the location of the designated areas for smoking, can the resident get there independently, can the resident independently light smoking materials safely, does the resident have tremors while smoking, can the resident extinguish the smoking materials in an appropriate receptacle, can the resident dispose of ashes or other tobacco related residue appropriately, has the resident had accidents or incidents with smoking materials, are there any visible burns on the resident clothing, Interdisciplinary team recommendations, determine if resident needs supervision, does resident require an apron, will cigarettes need to be kept at nursing stations, resident notified of restrictions, family or POA notified, staff notified of restrictions, smoking care plan in place, and the signatures of all interdisciplinary team members.
3/27/2015

All lighters have been removed from resident rooms and for those deemed "unsafe" cigarettes and smoking materials were removed and given to the Social Worker, however residents deemed "safe smokers" are allowed to keep cigarettes in their room. Lighters for "safe smokers" must be obtained from the Nurse and returned to the nurse at the nursing station when smoking has been completed.
3/27/2015

The residents that smoke were met with

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individually by the Director of Social Services to explain the new smoking policy and what their assessment results were whether "safe" or "unsafe". The residents were requested to sign the "safe" or "unsafe" smoking policy depending on their assessment.
3/27/2015

C.
The facility inter-disciplinary team developed a safe smoking data collection form to assess residents that wish to smoke. All residents that smoke have been assessed and care plans were updated by the MDS nurse to reflect "safe" or "unsafe" smoker.
3/27/2015

The facility has maintained the current designated smoking area which is the front center courtyard. Various departments have been assigned supervised smoking times being at 8 A.M, 10 A.M., 1:30 P.M., 4:00 P.M., 7:00 P.M. and 9:00 P.M. Residents assessed as safe smokers may smoke as preferred.
3/27/2015

Facility in-service is in progress and being conducted by the Director of Nursing, Staff Development Coordinator and the Clinical Coordinator with all staff on the new smoking policy, staff responsibility and disciplinary action if the policy is not followed with regard to resident smoking. Staff are not allowed to work until they have been in-serviced on the new policy.
3/28/2015

The smoking policy will be added to the orientation program for new staff effective immediately.

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F 323	Continued From page 92 3/27/2015 Immediate Jeopardy was removed on 03/28/15 at 7:45 PM when interviews with nursing staff and residents confirmed they had received inservice training on the facility's new smoking policy and procedures and the expected action to take when a resident was found to not follow the smoking policy. Record reviews confirmed that all current residents who smoke had updated smoking assessments and care plans. Observations confirmed that all smoking materials for unsafe smokers were secured with only cigarettes in the possession of safe smokers. Residents designated as safe smokers were observed to follow the new smoking policy in obtaining and returning lighters to the charge nurse and smoked in the designated resident smoking area. Residents designated as unsafe smokers were observed smoking with staff supervision in the designated resident smoking area, at the designated times and with smoking material secured by staff.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to administer medicated ophthalmic solutions (eye drops) as ordered by the physician which resulted in a significant medication error for 1 of 5 residents reviewed for unnecessary medications (Resident #78). The findings	F 333	The facility will ensure that residents are free from any significant med errors. The DON and RN Supervisor/Clinical Coordinator re-educated the nursing staff from March 30, 2015 to April 16, 2015 on	4/17/15

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F 333	Continued From page 93 included: Review of manufacturer's guidelines for use of Prednisolone Acetate (a corticosteroid) opthalmic solution revealed the following: "Prednisolone ophthalmic solution is only meant to be used for a short period of time. Do not use for longer than 1 week unless the physician advises otherwise. This is because it can cause problems within the eye when used for longer than recommended." Review of manufacturer's guidelines for use of Besivance (an antibiotic opthalmic solution) revealed it should only be given for 7 days. Resident #78 was admitted to the facility on 11/16/11 with diagnoses including hypertension, bipolar disorder with psychotic features and Alzheimer's disease. The most recent Minimum Data Set (MDS) assessment dated 02/13/15 indicated Resident #78 had no cognitive impairment for daily decision making. The MDS assessed the resident with impaired vision and indicated she could see large print but not regular print in books and magazines. The MDS indicated she wore corrective lenses. Further review of Resident #78's medical record revealed a physician's progress note by an ophthalmologist dated 02/27/15 which indicated Resident #78 was seen for a post-operative visit following cataract surgery to the right eye on 02/20/15. There was not a progress note or any documentation on Resident #78's medical record that indicated the resident had cataract surgery on her left eye. Review of Resident #78's physician's orders revealed an order dated 02/20/15 which read:	F 333	medication administration. Resident #78 orders have been clarified with the physician and the medications are being administered according to the physician orders and manufacturers recommendations. The order has been transcribed to the MAR by the nurse and verified by the RN/Clinical Coordinator. The verification has been given to the DON. The Medical Records Clerk will make a copy of all the telephone orders. The RN Supervisor/Clinical Coordinator will check all orders against the MARS and TARS to ensure they have accurately been transcribed. The RN Supervisor/Clinical Coordinator will initial them as verification. All copies and the audit tool will be brought to the DON with verification initials for each physician order. The audit of physician orders will be an ongoing process. These audits are done 3-5x per week by the RN Supervisor/Clinical Coordinator. The RN Supervisor/Clinical Coordinator will review with the DON and Adminstrator 3-5x per week. The DON or RN Supervisor/Clinical Coordinator will report the results of the audits to the QAPI committee for a period of 3 months.	

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Prednisolone acetate 1% 1 drop to right eye three times a day for 10 days, then 1 drop to right eye two times a day for 10 days then 1 drop to right eye once a day for 10 days; Timolol 0.5% 1 drop to right eye every morning. There were no orders on the medical record for eye drops to the left eye.

Review of Resident #78's February and March 2015 Medication Administration Records (MARs) revealed documentation that the Prednisolone and Timolol eye drops were given as ordered in February to the right eye. Documentation on the March MAR indicated the Prednisolone acetate 1% 1 drop two times a day to the right eye was completed on 03/12/15. Prednisolone acetate 1% 1 drop to right eye once daily was listed on the March MAR to be given 03/13 - 03/22/15 but the entry had been crossed through and the medication was not signed as given. Timolol 0.5% 1 drop in right eye every morning was listed on the March MAR but "right" had been crossed out and "left written" in above it. According to the March MAR Resident #78 was not given the Prednisolone for 10 days once daily in the right eye from 03/13 - 03/22/15 as ordered and was not given the Timolol once daily as ordered in the right eye after 02/28/15.

Listed on the March 2015 MAR were:
1. Prednisolone Acetate 1% instill one drop in operated eye three times a day---start after surgery with "L" written in above "operated eye" - the medication was documented as given three times a day 03/06 -03/13/15.
2. Prednisolone Acetate 1% instill one drop in the right eye every day for ten days with "right" crossed out and "left" written in above it - the medication was documented as given once daily

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F 333	Continued From page 95 03/01 - 03/28/15. 3. Besivance 0.6% - starting 2 days before surgery instill one drop in operated eye three times a day with "L" written in above "operated eye" - the medication was documented as started on 03/04/15 and given three times a day through 03/28/15 at 2:00 PM. An interview with Nurse # 6 on 03/28/15 about Resident #78's eye drops revealed Resident #78 had cataract surgery on her left eye on 03/06/15. Nurse #6 was unable to locate orders for eye drops to the left eye on the resident's chart and stated they might be in Medical Records. Upon request, the Medical Records coordinator checked for any unfiled documents for Resident #78 and located a physician's progress note from the ophthalmologist dated 03/13/15. Review of the progress note revealed the following medications listed to be administered post-operatively: 1. Timolol 0.5% 1 drop to left eye every day. Discontinue Timolol 0.5% to right eye on 03/06/15. 2. Prolensa 0.07% 1 drop every day as directed in the operative eye after surgery 3. Prednisolone Acetate 1% 1 drop three times a day as directed in the operative eye after surgery 4. Besivance 0.6% 1 drop three times a day in left eye - discontinue 03/13/15. An interview on 03/28/15 at 7:40 PM with the Director of Nursing (DON) revealed Resident #78's ophthalmologist always sent post-operative instructions for the eye drops with specific details about their administration. The DON was unable to explain why the instructions were not available on Resident #78's chart. The DON was unable to	F 333		

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F 333	Continued From page 96 explain why the Timolol and Prednisolone Acetate were not administered to Resident #78's right eye as ordered and stated it was a medication error. The DON was unable to explain why the Prednisolone Acetate 1% 1 drop was administered to Resident #78's left eye three times a day from 03/06 - 03/13/15 and once daily from 03/01 - 03/28/15. The DON stated usually the Prednisolone drops are tapered down and discontinued. The DON was unable to explain why the Besivance was administered to Resident #78's left eye from 03/04/15 - 03/28/15 when the physician's progress note indicated it was to be discontinued on 03/13/15.	F 333		
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 keep food preparation equipment clean and food service pans ready for use free from moisture; failed to label and date food stored in the kitchen refrigerator; failed to keep plastic containers of condiments, thickner, and a container for clean plastic wear free from build-up of sticky greasy residue and failed to	F 371	The facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities and will store, prepeare, distribute and serve food under sanitary condition.s The dietary staff was re-educated on 3/25/2015 by the Registeed Dietician and	4/17/15

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F 371	Continued From page 97 remove dented cans stored ready for use. In addition, the facility failed to serve food under sanitary conditions by not touching ready-to-eat foods for 10 of 10 residents observed during meals. (Residents #17, #21, #24, #31, #36, #45, #47, #59, #130 and #135) The findings included: 1. During the initial tour of the facility kitchen on 03/23/15 from 9:36 AM-10:05 AM the following concerns were identified: a. At 9:36 AM 2 large metal pans were observed ready for use in clean storage. The metal pans were stacked on top of each other and the interior of both pans was wet with moisture. On 03/23/15 at 9:36 AM the Assistant Dietary Manager, (ADM) stated service pans should be air dried and not stored wet with moisture. b. At 9:47 AM the interior of the microwave had spills and food debris and a bowl of soup was stored inside the microwave. 0n 03/23/15 at 9:47 AM the ADM stated the microwave should have been cleaned and food should not have been stored in the microwave. c. At 9:41 AM bologna wrapped in plastic wrap was observed stored in the refrigerator with no label and date. On 03/23/15 at 9:51 AM the ADM stated food items should be labeled and dated and discarded if there was no date or label. d. At 9:51 AM two wrapped sandwiches were observed in the refrigerator and were not labeled or dated. On 03/23/15 at 9:51 AM the ADM stated food items stored in the refrigerator should be labeled and dated and discarded if they had no date or label. e. At 9:56 AM a plastic container used to store clean plastic ware was observed with a build-up of sticky greasy residue on the top and sides of the container with food debris on the inside of the	F 371	Dietary Manager on microwave cleaning, labeling and storing foods, removal and no use of dented cans, cleaning of items in the dietary department to prevent a build up of sticky and greasy residue,and all items are to be air dried and not stored as wet. A comprehensive audit tool was developed by the Registered Dietician and Dietary Manager. Facility staff was re-educated from March 28, 2015 to April 16, 2015 on the proper way to serve trays to a resident. All foods without a label and date have been discarded. The interior of the microwave is being cleaned at the end of each night. An audit tool is completed and signed by the staff member closing the dietary department every evening. The Dietary Manager is verifying that the equipment is clean when arriving in the morning. The audit tool is reviewed with the Administrator 1 time per week. Any dented cans have been removed and placed in the appropriate area for return back to the food supplier for credit. All spices containers and other storage containers have been cleaned and do not have a build up of sticky, greasy residue. Residents 17, 21, 24, 31, 36, 45, 47, 59, 130, 135 are being served meals by the staff according to sanitary conditions by not touching ready to eat food.	

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F 371	Continued From page 98 container. On 03/23/15 at 9:59 AM the ADM stated the container should have been cleaned inside and out before storing clean plastic ware f. At 10:01 AM 2, 16 ounce dented cans of peaches were observed stored ready for use in dry storage. On 03/23/15 at 10:01 AM the ADM stated the two dented cans of peaches on shelving in dry storage should have been removed and placed on the designated area in dry storage for dented cans to be returned to the food service company for credit. g. At 10:20 AM a container of thickner and several containers of condiments including rosemary, mustard powder, garlic powder, lemon pepper, oregano, and cajun seasoning were observed stored on shelving in the food preparation area. The containers had a build-up of sticky, greasy residue on the tops and sides. On 03/23/15 at 10:20 AM the ADM stated the containers should have been wiped off and not stored with a build up of sticky, greasy residue. 2. Observation of the lunch meal was observed on the 200 hall on 03/23/15 beginning at 12:39 PM. revealed the following concerns: a. Nurse Aide (NA) #1 was observed to set up a lunch tray for Resident #21. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. b. NA #1 was observed to set up a lunch tray for Resident #31. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. c. NA #1 was observed to set up a lunch tray for Resident #36. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. d. NA #1 was observed to set up a lunch tray for Resident #59. She was observed to touch a	F 371	An audit tool was developed by the Registered Dietician and Dietary Manager and is done 4-7x per week by the Dietary Manager and 1x per week by the Administrator to ensure that the microwave is clean, food is dated and labeled, no dented cans are being used and they are removed and placed on a rack for return to the food supplier for credit, plastic spice and silverware containers are clean, and dishes, pots and pans are allowed to air dry before storage. An audit tool was developed by the Admninistrator and DON and is done 2-3x per week to monitor the delivery and set up of resident trays to ensure staff are following sanitation guidelines for meal service. The facility is currently in contract negotiations with Healthcare Services Group to provide dietary services beginning May 1, 2015. The results of the audits are discussed with the Administrator on a weekly basis. The Dietary Manager will report monthly to the QAPI committee for a period of 3 months regarding kitchen compliance. The Administrator will report monthly to the QAPI committee for a period of 3 months the delivery of meals to residents and observing senitation guidelines.	

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F 371	Continued From page 99 piece of bread with her hands as she removed it from a paper bag. e. NA #1 was observed to set up a lunch tray for Resident #24. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. f. NA #1 was observed to set up a lunch tray for Resident #45. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. g. NA #1 was observed to set up a lunch tray for Resident #17. She was observed to touch a piece of bread with her hands as she removed it from a paper bag. Another observation of the lunch meal was conducted on the 200 hall on 03/27/15 beginning at 12:47 PM. h. NA #1 was observed to set up a lunch tray for Resident #47. She was observed to touch a dinner roll with her hands as she removed it from a paper bag. i. NA #1 was observed to set up a lunch tray for Resident #135. She was observed to touch a dinner roll her hands as she removed it from a paper bag. j. NA #1 was observed to set up a lunch tray for Resident #130. She was observed to touch a dinner roll with her hands as she removed it from a paper bag. An interview was conducted with the Director of Nursing (DON) on 03/28/15 at 7:59 PM. She stated staff should not touch a resident's food with bare hands.	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	F 441		4/17/15

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F 441	Continued From page 100 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 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 of 1 of 3 nurses (Nurse #5) observed during medication administration to	F 441	The facility will maintain an Infection Control Program designed to provide a	

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F 441	Continued From page 101 2 of 4 residents (Residents #41 and #30), facility staff failed to wash or sanitize their hands between residents. The findings included: On 03/24/15 at 4:00 PM Nurse #5 was observed during medication administration. Nurse #5 entered the room of Resident #41, donned gloves and checked the resident's blood glucose (BG). She exited the resident's room, removed the gloves and discarded them in the trash can on the medication cart. Without washing or sanitizing her hands, Nurse #5 unlocked the medication cart and removed several bubble packs of medication from the cart. On 03/24/15 at 4:05 PM Nurse #5 was interrupted by the surveyor, before she prepared the medications, and asked what the facility protocol was for washing or sanitizing her hands after doing a BG. Nurse #5 stated she should wash or sanitize her hands, but did not do either, and proceeded to prepare Resident #41's medications, which included oral medications, eye drops and insulin. Nurse #5 entered Resident #41's room and gave the resident the cup containing her oral medication, then donned gloves and administered an insulin injection in the resident's abdomen. Wearing the same gloves, she then administered eye drops to both of Resident #41's eyes. Nurse #5 exited the resident's room, removed her gloves and discarded them in the trash can on the medication cart, discarded the insulin syringe in the sharps container, unlocked the medication cart and returned the eye drops to the medication cart. On 03/24/15 at 4:15 PM without washing or sanitizing her hands, Nurse #5 removed Resident	F 441	safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infections. The DON, RN Supervisor/Clinical Coordinator re-educated licensed staff from March 28, 2015 to April 16, 2015 on proper handwashing, glove changes, and medication administration. All staff was re-educated by the DON and RN Supervisor/Clinical Coordinator on disposing of dirty linen, handwashing, use of gloves, and serving of food to residents from March 28, 2015 to April 16, 2015. The facility protocal is taught during the orientation process and then annually thereafter. The DON, RN Supervisor/Clinical Coordinator will observe medication pass and patient care 1-2 times per week to ensure that staff are following the facility protocal on infection control. Resident #41 is having eye medications administered according to the facility protocal. The DON, RN Supervisor/Coordinator will report the results of the audits to the Administrator on a weekly basis. The DON will report to the QAPI committee the results of the audits for a period of 3 months.	

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F 441	Continued From page 102 #30's medications from the medication cart. At that time Nurse #5 was interrupted by the surveyor, before she prepared the medication, and asked again what the facility protocol was for washing or sanitizing her hands after doing a procedure that required wearing gloves. Nurse #5 responded: "Do you want me to give this medicine or wash my hands?" She was summoned to assist another resident and was observed sanitizing her hands prior to returning to the medication cart to pour Resident #30's medication. An interview with the Director of Nursing (DON) on 03/28/15 at 6:38 PM about the facility's protocol for washing or sanitizing hands after doing a procedure in which staff wore gloves revealed the staff should wash their hands before and after the procedure. The DON stated the nurses should change their gloves and at least use hand sanitizer between administering an injection and giving eye drops. When asked what her expectation was for handwashing by staff after performing a BG, the DON stated she expected the nurse to wash her hands after doing the BG and before preparing medications. When asked what her expectation was for handwashing after administration of eye drops and insulin injection, the DON stated she expected the nurse to remove the gloves and wash her hands in the resident's room, who received the eye drops and insulin, before leaving the resident's room and preparing medication for another resident. The DON stated every nurse was taught hand hygiene as part of the Infection Control training that was provided during orientation.	F 441		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		4/17/15

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F 490	Continued From page 103 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility administration failed to review the smoking policies in conjunction with smoking practices in place in the facility to effectively manage residents that smoked which affected 13 of 17 sampled residents. (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126, #129, #131, #132, #133). Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/14 at 7:45 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 E (a pattern, 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 related to resident smoking.	F 490	The facility is being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highesst practicable physical, mental, and psychosocial well-being of each resident. The interdisciplinary team met and developed a new smoking policy. The Adminstrator was involved in the development of the new smoking policy and will be involved in the enforcement of the policy with periodic reviews for compliance which will presented to the QA/QAPI committee on a monthly basis or more frequently if necessary. The Administrator and Director of Admissions updated the admission packet to include a summary of the smoking policy. The summary explains that a resident is not allowed to smoke until a "safe smoking collection tool has been completed" by a licensed nurse. The resident is considered an "unsafe smoker" until the IDT meets on the next working day to review all the data. The resident will need to give the Admissions Director or facility staff member their cigarettes	

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F 490	Continued From page 104 The findings included: Cross refer F323. The facility failed to implement and enforce smoking rules for 13 of 17 sampled residents. Three of the 13 sampled residents were allowed to retain smoking material in their room after staff discovered them smoking within the facility. On 03/26/15 at 6:40 PM the Administrator and Director of Nursing were notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/28/2015 at 11:59 AM. Credible Allegation of Compliance A. Residents 1-13 (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126, #129, #131, #132, #133 on the 2567)had smoking materials in their room and or in their possession. B. The Interdisciplinary team met to develop a new smoking policy. The Administrator was involved in the development of the new smoking policy and will be involved in the enforcement of the policy with periodic reviews for compliance which will be presented in the monthly QA meeting. All smoking materials will be kept in plastic containers on the 200 hall med rom, however residents that are deemed "safe" smokers can keep their cigarettes in their rooms. 03/25/2015 On 03/25/15, the Director of Admissions updated the admission packet to include the revised smoking policy and will explain that no smoking is	F 490	and lighter upon arrival into the facility. No lighters, butane, matches or any other lighting material is able to be kept by any resident. The resident/responsible party will sign that they understand and agree to abide by the facility smoking policy. The Admninistrator will review 1-2 times per week admission packets to ensure that the new smoking policy has been signed by the resident, family or RP. A review of the "safe smoking data collection tool" was completed by the IDT team including the Administrator on 3/28/2015, 4/7/2015, 4/15/2015 to ensure that it is an effective tool. No revisions were made to the Safe Smoker Data Collection Tool at that time. All smoking materials will be kept in a plastic container in the 200 hall med room however residents that are deemed "safe smokers" can keep their cigaretts in their rooms. The Administrator will audit 1-2x per week that the smoking materials will be stored properly in the 200 hall med room. The Administrator will be auditing the Weekend Smokng Observation tool completed by the Weekend Manager on Duty to ensure compliance with the new smoking policy on the weekends. All weekend manager reports are turned in on Monday morning during the morning Department Manager Meeting. The Administrator will review and report 1x per week for 4 weeks the results of	

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F 490	Continued From page 105 permitted by the resident until the new smoking data collection tool has been completed by a licensed nurse. The evaluating nurse will inform the Interdisciplinary team of the evaluation. The team will review the information and make a determination based on the information whether the resident is "safe" or "unsafe." The Director of Social Services will inform the resident of the parameters in which they are allowed to smoke while a resident in this facility. The resident will need to sign off that they and their family understand this policy. The Administrator will review 1-2 times per week admission packets to verify that the resident and or family/RP signed the new smoking policy. 03/25/2015 A review of the Safe Smoking Data Collection tool was completed on March 25, 2015 by the inter-disciplinary team including the Administrator with revisions that now include: Does the resident know the location of the designated areas for smoking, can the resident get there independently, can the resident independently light smoking materials safely, does the resident have tremors while smoking, can the resident extinguish the smoking materials in an appropriate receptacle, can the resident dispose of ashes or other tobacco related residue appropriately, has the resident had accidents or incidents with smoking materials, are there any visible burns on the resident clothing, Interdisciplinary team recommendations, determine if resident needs supervision. All smoking materials will be kept in a plastic box at the 200 hall med room, however residents that have been deemed "safe smokers" will be allowed to keep cigarettes in their room. Residents were notified of restrictions, family or	F 490	the resident audit tool to ensure that all smokers have been identified. Any resident indicating that they have smoked in the last month will have a Safe Smoker Data Collection Tool completed regardless of whether they are smoking at that time or not. The results of the Safe Smoker Data Collection Tool will be signed by the IDT members, the care plan will be updated, and they will be added to the appropriate smoker list (safe or unsafe) even if they are not smoking at that particular time. The Administrator will review 1x per week any new residents that have been admitted to ensure that their care plan is completed with regards to smoking. The DON or RN Supervisor/Clinical Coordinator will audit any 15 minute checks for residents that have not followed the safe smoker policy or had an infraction of the policy. This can be done through AHT nursng notes indicating 15 minute checks have been completed for thier shift or 15 minute log sheet. The DON will review with the Administrator that all of the 15 minute monitoring checks have been completed as they arise. The Adminstrator is responsible for auditing the following or reviewing with the individuals assigned: Resident Fund balances and bond audit 1x per month or more often if there is an increase in admissions and this will include audit review with BOM.	

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F 490	Continued From page 106 POA were notified by letters outlining the new policy and they were sent out by the Director of Social Services. Staff notified of restrictions, smoking care plan in place, and the signatures of all interdisciplinary team members. 03/27/2015 The MDS Nurse or licensed nurse will complete the safe smoking data collection tool. Residents were informed of the outcome of the safe smoking data collection tool by the Director of Social Services and signed the appropriate document to ensure their understanding of the new policy. 03/27/2015 C. Enforcement of the policies will be done by the Administrator through audit tools appropriate to the policy including supervised smoking audits, observation of residents determined to be considered "safe smokers", audit of the storage of smoking materials not allowed to be kept in resident rooms. Failure to meet the goals of the policy will require review and changes to enhance the policy and its benefit to the resident. On 03/27/2015, the Director of Nursing, the Clinical Coordinator or the Staff Development Coordinator staff began in-servicing staff on changes to policies and will require signature of in-service sheet and in some instances signature of the actual policy. Staff that fails to carry out the policies of this facility and company will be re-educated and then if the problem persist, progressive disciplinary action may be involved. Staff will not be allowed to work until they have been in-serviced on the new policy. 03/28/2015	F 490	Audit review with the Maintenance Director weekly for compliance with F253, review with the DON or RN Supervisor/Clinical Coordinator 1x per week F281 the professional standards of quality, F309 Monday-Friday audit result reviews with the Director of Nursing or Administrator, F312 reviewed 1x per week, F333 will be reviewed daily with the Director of Nursing or Administrator, F371 1x per week audit by the Administrator and review weekly with the Dietary Manager, and F441 audit results reviewed by Administrator weekly. The Administrator is responsible for the Smoking Compliance Program F323. The results of any aduits done in this program will be discussed at the morning department manager meeting Monday-Friday. The Administrator is responsible for implementing new company policies as appropriate to the facility and with the Medical Director and Corporate approval. Any new policies developed and seeking approval will be approved, denied or revised within 1 week of being presented to the Medical Director or Corporate Office. Policies that are currently in effect and require revision will be revised by the facility and present to the Corporate for approval with approval anticipated to be received within 2 weeks of the date presented. New policies or procedures will be brought to the QA/QAPI meeting for review and	

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F 490	Continued From page 107 Beginning on 03/27/2015 and ongoing a review of policies will be done by the inter-disciplinary team from the Heaton Manual, Healthtique Policies, or a similar resource to ensure that the policies meet the needs of the residents and utilizes the resources effectively and efficiently for the utmost well being of the resident. A list of reviewed policies will be kept in the QA book and recommendations will be discussed and acted upon, if appropriate after the QA committee has discussed the policy. 03/27/2015 and ongoing Immediate Jeopardy was removed on 03/28/15 at 7:45 PM when interviews with nursing staff and residents confirmed they had received inservice training on the facility's new smoking policy and procedures and the expected action to take when a resident was found to not follow the smoking policy. Record reviews confirmed that all current residents who smoke had updated smoking assessments and care plans. Observations confirmed that all smoking materials for unsafe smokers were secured with only cigarettes in the possession of safe smokers. Residents designated as safe smokers were observed to follow the new smoking policy in obtaining and returning lighters to the charge nurse and smoked in the designated resident smoking area. Residents designated as unsafe smokers were observed smoking with staff supervision in the designated resident smoking area, at the designated times and with smoking material secured by staff.	F 490	approval by the facility Team. They will not be presented until Corporate approval has been received. All specific Ftags will be reported monthly in the QA/QAPI meeting by the person designated for period of 3 months.	
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		4/17/15

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F 520	Continued From page 108 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to implement and enforce smoking rules for 13 of 17 sampled residents and failed to identify inconsistencies with the smoking policies and implement measures to prevent reoccurrence of residents smoking within the facility. Three of 13 sampled residents (Residents #86, #96 and #133) were allowed to retain smoking material in their room after staff discovered them smoking within the facility. (Residents #23, #36, #44, #47, #73, #86, #91,	F 520	The facility has a QA committee that includes at a minimum the Director of Nursing, a Physician, and 3 other staff members. The Administrator and Director of Nursing are the facilitators of the QA/QAPI meeting. The facility QA/QAPI committee meets on a monthly basis to identify concerns with respect to quality assurance and to	

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F 520	Continued From page 109 #96, #126, #129, #131, #132, #133). Immediate Jeopardy began on 02/05/15 when Resident #96 smoked in his room while the roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/14 at 7:45 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 E (a pattern, 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 related to resident smoking. The findings included: 1. Cross refer F323. The facility failed to implement and enforce smoking rules for 13 of 17 sampled residents. Three of the 13 sampled residents were allowed to retain smoking material in their room after staff discovered them smoking within the facility. On 03/26/15 at 6:10 PM the administrator and Director of Nursing (DON) stated issues with smoking had never been addressed through the Quality Assessment and Assurance committee. The administrator and DON stated they dealt with residents smoking inside the facility on an individual basis and didn't feel the issue was widespread.	F 520	assess the operations of the facility and implement interventions required to correct concerns and meet the needs of the residents. The QA/QAPI committee met on March 25, 2015 to discuss the smoking policy, and then on March 30, 2015 to reviewe the policy and it's effectiveness of the newly revised policy. Areas that are identified as concerns will have the policy reviewed to ensure that the facility is following the policy and that if there are changes that need to be made they are revised and implemented along with the necessary monitoring tools to ensure continued compliance. The incident/event log is brought to each QA/QAPI meeting for reveiw to identify any additional patters, trends, concerns. A summary of incidents/events will be presented during the meeting from the weekly review done by the Adminstrator. All areas of concerns will be addressed immediately by the Administrator. The resident audit tool was updated on 3/27/2015 to include two questions to assist in the identification of other residents that smoke that previously did not indicate that they smoked. The questions are 1) have you ever smoked, and 2) if you have smoked in the past, how long ago? This resident audit tool cumulative information will be prsented at each	

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F 520	Continued From page 110 The administrator stated she assumed the Smoking Policy in the admission packet was the same as the Smoking Policy in the new corporate policy manual sent December of 2014. The administrator stated the corporate office had instructed her to inform them of any discrepancies in the December 2014 policy manual and existing policies so they could be reviewed. The administrator stated because she had not reviewed the admission Smoking Policy or the Smoking Policy manual in the December 2014 manual prior to 03/25/15 she was not aware of the discrepancies. On 03/26/15 at 6:40 PM the Administrator and Director of Nursing were notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/28/15 at 11:59 AM. Credible Allegation of Compliance A. Residents 1-13 (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126, #129, #131, #132, #133 on the 2567) had smoking materials in their room and or in their possession. The Interdisciplinary team met to develop a new smoking policy. The Administrator was involved in the development of the new smoking policy and will be involved in the enforcement of the policy with periodic reviews for compliance which will be present in the monthly QA meeting. All smoking materials will be kept in plastic container on the 200 hall med room, however residents that are deemed "safe" smokers can keep their cigarettes in their room. 03/25/2015	F 520	QA/QAPI meeting by the Adminisrator. The Administrator will present information on Safe Smoking Compliance including any problems, concerns, changes and challenges. The Administrator will present policies and procedures that are currently at the Corporate Office for review or pending approval for implementation. The facility Administrator will review at least 2 policies per momth from the Healtique Policy and Procedure Manual, the Heaton Manual or other similiar resources to ensure that we are following the policy, make recommendations for changes, and implemention goals for new programs. The DON,RN Supervisor/Clinical Coordinator audit results for F312 and other nursing items to the QA/QAPI committee regarding all nursing compliance programs. The Maintenance Director will present all audits results for F253 to the QA/QAPI committee that are related to maintenance, environment, or life safety. The Dietary Manager will present all audit results for F371 to the QA/QAPI committee with regard to the dietary department complaince, sanitation, infrection control and food preparation. The BOM will present all audits and work done on the Resident Trust, Bond Verificiaton, Deceased Resident Funds	

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F 520	Continued From page 111 On 03/25/15, the Director of Admissions updated the admission packet to include the revised smoking policy and will explain that no smoking is permitted by the resident until the new smoking data collection tool has been completed by a licensed nurse. The evaluating nurse will inform the Interdisciplinary team of the evaluation. The team will review the information and make a determination based on the information whether the resident is "safe" or "unsafe." The Director of Social Services will inform the resident of the parameters in which they are allowed to smoke while a resident in this facility. The resident will need to sign off that they and their family understand this policy. The Administrator will review 1-2 times per week admission packets to verify that the resident and or family/RP signed the new smoking policy. 03/25/2015 Enforcement of the policies will be done by the Administrator through audit tools appropriate to the policy including supervised smoking audits, observation of residents determined to be considered "safe smokers", audit of the storage of smoking materials not allowed to be kept in resident rooms. Failure to meet the goals of the policy will require review and changes to enhance the policy and its benefit to the resident. Beginning on 03/27/15, the Director of Nursing, the Clinical Coordinator or the Staff Development Coordinator staff will be in-serviced on changes to policies and will require signature of in-service sheet and in some instances signature of the actual policy. Staff that fails to carry out the policies of this facility and company will be re-educated and then if the problem persist, progressive disciplinary action may be involved.	F 520	returned to the State, any overages anticipated in the Resident Trust, any balances within $200 limit of the allowed amount which could affect Medicaid eligibility or SSI to the QA/QAPI committee. The Admission Coordinator will report on all new admissions, how many of them smoke, and verify that all the proper documents were signed during the admission process such as understanding the facility smoking policy to the QA/QAPI committee. The Social Services Director will report any situations of residents refused to sign the smoking policy or they are having problems with the smoking policy to the QA/QAPI committee. The MDS/Care Plan staff will report any changes to the Care Plans of residents. The audit will be discussed where care plans are verified as accurate and timely on each resident to ensure continued compliance to the QA/QAPI committee. The cross referenced items are listed under F253, F312, and F371. They are also referenced in this particular F tag, see above. The QA/QAPI process is ongoing.	

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F 520	Continued From page 112 03/27/2015 B. On 03/27/15, the Resident Audit Tool has been used by the facility to identify residents that have the potential to be affected by deficient practices was updated. On 03/27/15 two questions were added to the audit tool which are: 1. Do you smoke? If so, the MDS staff was to immediately do a safe smoking data collection form and updated the care plan accordingly. 2. Have you ever smoked? If so, how long ago? If they have smoked in the last month prior to admission a safe smoking data collection form will be completed on the resident by the MDS nurse. The resident audit tool was updated to ask the question for a period of 4 weeks for existing residents to ensure that the facility is identifying potential smokers that did not disclose their prior smoking habits, if any. The results of that information will be brought to the QA committee on a monthly basis for review however if someone is identified, the person conducting the resident interview will notify the DON and Administrator immediately for follow up. 03/27/2015 C. The event/incident logs will be brought to the inter-disciplinary morning department meeting for discussion to identify any trends, patterns or concerns regarding any resident in the facility that would pose a safety concern including any new resident assessments, unsafe smoking incidents, and any other smoking infractions which will be followed up on by the Administrator immediately. 03/27/2015	F 520		

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QA meetings will take place on a monthly basis with the Administrator, DON, designated physician, and at least 3 other staff members. Quarterly QA meetings will take place with at least the Administrator, DON, designated physician, 3 other staff members, and pharmacy, X-ray and lab will also be invited to attend. One certified nurse aide or licensed nurse will be invited to attend each QA meeting that provides direct care to residents to help the committee identify any potential concerns regarding resident safety.
03/27/2015

Staff will not be allowed to work until they receive this in-service training, so on 03/27/15, the DON, Clinical Coordinator and Staff Development Coordinator began in-servicing all staff before beginning their shift on the revised smoking policy, QA, and their responsibility to ensure that all residents are monitored for safety and any concerns are to be reported immediately to the Administrator or DON for appropriate follow up.
03/28/2015

Audit tools will provide a synopsis of trends or patterns and will be discussed at monthly QA meetings with interventions that should have been implemented throughout the month, so a review of the interventions will be done to ensure they are working and meeting the needs of the residents to ensure the safety of all residents that reside in the facility. Interventions that are not meeting the safety requirements will be modified to meet the needs by the QA committee.
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Audits will be done on safety areas/concerns by the inter-disciplinary team and will be discussed

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at morning department manager meetings with results of the audits discussed at the monthly QA meeting. A line item will be added to the morning department manager sheet to include questions about QA items.
03/27/2015

Monthly QA summaries will be posted for the staff to review and make suggestions on how to enhance the safety of every resident in areas that show trends or patterns.
03/27/2015

The next monthly QA meeting is March 30, 2015.
03/27/2015

Immediate Jeopardy was removed on 03/28/15 at 7:45 PM when interviews with nursing staff and residents confirmed they had received inservice training on the facility's new smoking policy and procedures and the expected action to take when a resident was found to not follow the smoking policy. Record reviews confirmed that all current residents who smoke had updated smoking assessments and care plans. Observations confirmed that all smoking materials for unsafe smokers were secured with only cigarettes in the possession of safe smokers. Residents designated as safe smokers were observed to follow the new smoking policy in obtaining and returning lighters to the charge nurse and smoked in the designated resident smoking area. Residents designated as unsafe smokers were observed smoking with staff supervision in the designated resident smoking area, at the designated times and with smoking material secured by staff.

Based on observation, record review and staff

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interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2014. This was for three recited deficiencies which were originally cited in September of 2014 on a recertification and complaint follow-up survey . The deficiencies were in the areas of housekeeping and maintenance services, activities of daily living and kitchen sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

Cross refer to:

a. F253: Housekeeping and Maintenance Services. Based on observations and staff interviews, the facility failed to secure toilets to the floor for 3 of 5 sampled bathrooms and failed to secure ceiling tiles for 1 of 5 sampled bathrooms.

During a recertification/complaint survey of 09/12/14 the facility was cited for F253 for failing to secure and maintain wall unit air conditioners.

b. F312: Activities of Daily Living: Based on observations, medical record reivew and interviews the failed failed to provide nail care to 1 of 4 sampled dependent residents.

During a recertification/complaint survey of 09/12/14 the facility was cited for F253 for failing to provide assistance with eating and nail care.

c. F371: Kitchen Sanitation: Based on observations and staff interviews the facility failed to keep food preparation equipment clean

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F 520	Continued From page 116 and food service pans ready for use free from moisture; failed to label and date food stored in the kitchen refrigerator; failed to keep plastic containers of condiments, thickner, and a container for clean plastic wear free from build-up of sticky greasy residue and failed to remove dented cans stored ready for use. In addition, the facility failed to serve food under sanitary conditions by not touching ready-to-eat foods for 10 of 10 residents observed during meals. During a recertification/complaint survey of 09/12/14 the facility was cited for F371 for failing to wash hands and change gloves prior to handling food. On 03/28/15 at 6:30 PM the Administrator and Director of Nursing stated the areas of housekeeping and maintenance services, activities of daily living and kitchen santiation had all been included in the ongoing monthly Quality Assessment and Assurance Committee meetings. The Administrator explained after the last survey in September 2014 efforts were made to address these areas through changes in management staff, inservices, and weekly monitoring of resident care but that it was a work in progress. The administrator stated the focus since the September 2014 recertification/complaint survey had been on the follow-up survey and maintaining overall compliance.	F 520		