STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews, the facility failed to honor preferences related to smoking for 2 of 2 residents reviewed who were assessed to be safe smokers (Resident #21 and Resident #119). The findings included: 1) A review of the facility ' s policy on Smoking (Revised 1/20/17) included the following procedures, in part: "1. Residents that smoke will be evaluated for upon admission, quarterly, and with a change of condition to determine their ability to smoke safely and what additional adaptive or safety equipment is needed. 2. Residents deemed unsafe to smoke independently will be supervised during smoking. Staff will be assigned to supervise residents."	F 242	F242 QOL r/t self choice SMOKERS 1)On 6/14/17 , the licensed nurse completed an updated smoking assessment and safety care plan for resident #21 and #119 to reflect their right to safely smoke independently at times of their choice. 2)On 7/5/17, Licensed Nurse Re-evaluated current residents who choose to smoke ability(ies) to safely smoke and updated their safety care plans accordingly. Safe smokers have been reeducated on their right to smoke independently at times of their choice and smoking materials are to be maintained by facility staff for safety of all residents. 3)On 6/29/17, Director of Clinical Services	7/13/17

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

Electronically Signed | 07/06/2017

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F 242	Continued From page 1 Resident #21 was admitted to the facility on 1/17/17. He re-entered the facility on 2/22/17 with a cumulative diagnoses which included atherosclerotic heart disease. A review of the resident's medical records included an Admission / Readmission Data Collection form dated 2/22/17. Section N of the form was entitled, "Safety," which included a Safe Smoking Evaluation addressing six observations. Each of the six observations for Resident #21 were checked with a "yes" answer. The last section on the Safe Smoking Evaluation indicated the resident was determined to be a "Safe Smoker." A review of Resident #21 ' s most recent quarterly Minimum Data Set (MDS) dated 5/1/17 revealed the resident was assessed to be cognitively intact. The MDS assessment revealed he required supervision only for each of his Activities of Daily Living (ADLs). A review of Resident #21 ' s current care plan (revised on 5/1/17) included a focus area on the topic of "Safety." The Care Plan interventions included, in part: safe smoking assessment on admission and quarterly; instruct resident on smoking protocol; keep smoking materials locked at nurse ' s station; provide designated smoking area for residents; monitor for continued safe smoking; and provide scheduled staff supervised smoking times. Review of a Smoking Schedule provided upon entrance to the facility on 6/12/17 read, in part: "In order to endure resident safety, [Name of facility] has implemented scheduled smoking times..." The scheduled smoking times were	F 242	reeducated facility staff on residents rights to self choice and the facilities updated smoking policy. A Resident Smokers list is posted at the nurses station to alert staff of safe/unsafe smokers and staff-assisted smoking times for unsafe smokers. Unsafe smokers have posters in their rooms that display the facilities supervised smoking times. A designated smoking area is clearly marked and safety equipment available. On 6/29/17, the Director of Clinical Services re-educated licensed nurses on the accurate completion of the smoking evaluation on the Admission and Quarterly Data Collection and the Safe Smoking Evaluation upon admission, readmission, quarterly, or with changes in smoking status or ability to safely smoke. Newly hired nursing staff will be educated upon hire. 4)Social Services Designee To complete quality improvement monitoring of resident smokers to ensure safe smokers right to smoke independently at times of their choice is being honored. Monitoring will be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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listed as: 9:30 AM - 9:45 AM; 11:30 AM - 11:45 AM; 1:30 PM - 1:45 PM; 3:30 PM - 3:45 PM; and, 6:30 PM - 6:45 PM.

Review of a Smokers ' List provided upon entrance to the facility on 6/12/17 included 12 residents. Resident #21 was listed as a safe smoker. Only one of the 12 residents listed was designated as an unsafe smoker.

An interview was conducted on 6/13/17 at 10:00 AM with Nursing Assistant (NA) #5. When asked what the facility ' s procedures were if a resident wanted to smoke at times other than the designated smoking times, the NA hesitated and shook her head. The NA indicated she had not been presented with that situation.

An observation was conducted on 6/13/17 at 11:40 AM as Resident #21 was smoking in the facility ' s designated smoking area. NA #4 was observed to be supervising residents in the designated smoking area during the designated smoking time.

An interview was conducted on 6/14/17 at 1:00 PM with Resident #21. During the interview, the resident was asked about the facility's smoking policy. The resident reported there were 5 smoking breaks per day. He stated these were, "the only times we can go out to smoke." The resident added, however, that he "might" be able to go out to smoke again around 8:00-9:00 PM if he could get a nursing assistant to go out with him. When asked why he needed supervision, the resident stated, "At my age, I always just follow the rules." When asked if there are other times (other than the designated times) when he would like to go out to smoke, the resident stated,

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"Oh yeah." Upon further inquiry, the resident stated smokers were allowed to smoke only 2 cigarettes during each designated smoking time. When asked why this was the case, the resident shrugged his shoulders and said that was what he had been told. He also added that since the smoking breaks were only 15 minutes long, there wasn ' t time to smoke more than two cigarettes.

An interview was conducted on 6/14/17 at 2:45 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the Administrator reported that although the facility had designated smoking times, a resident could ask to smoke at another time and they would have a staff person go out with him/her for a smoking break. The Administrator confirmed a resident assessed to be a safe smoker was not allowed to go out by themselves to smoke.

An interview was conducted on 6/15/17 at 9:00 AM with Resident #21 upon his request. The resident reported he was told last night by a NA (unidentified) that he could request to go out and smoke at times other than the designated smoking times. The resident was smiling during the interview and appeared pleased.

An interview was conducted on 6/15/17 at 9:44 AM with NA #6. NA #6 was supervising the smoking break in the designated smoking area. The smokers included Resident #21. Upon inquiry, NA #6 stated the designated smoking time was 15 minutes and only 2 cigarettes were allowed during each smoking break. When asked what happened if a resident wanted to smoke at a time other than a designated smoking time, she stated, "We have to take them."

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An interview was conducted on 6/15/17 at 2:44 PM with the DON. Upon inquiry, the DON reported Resident #21 was a reliable historian.

A follow-up interview was conducted on 6/15/17 at 5:33 PM with the facility ' s Administrator regarding the smoking policy. Upon inquiry, the Administrator stated her expectation would be, "to follow the regulations."

2) A review of the facility ' s policy on Smoking (Revised 1/20/17) included the following procedures, in part:

"1. Residents that smoke will be evaluated for upon admission, quarterly, and with a change of condition to determine their ability to smoke safely and what additional adaptive or safety equipment is needed.

2. Residents deemed unsafe to smoke independently will be supervised during smoking. Staff will be assigned to supervise residents."

Resident #119 was admitted to the facility on 5/5/16. He re-entered the facility on 2/3/17 with a cumulative diagnoses which included chronic renal failure.

A review of Resident #119 ' s most recent quarterly Minimum Data Set (MDS) dated 3/7/17 revealed the resident was assessed to be cognitively intact. He required extensive for all of his Activities of Daily Living (ADLs) with the exception of requiring limited assistance with locomotion off the unit and supervision only for locomotion on the unit and for eating.

A review of the resident's medical records revealed a Quarterly Data Collection form dated 3/10/17 included a safe smoking assessment.

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The resident was determined to be a "Safe Smoker."

A review of Resident #119 ' s current care plan (revised on 3/24/17) included a focus area on the topic of "Safety." The Care Plan interventions included, in part: safe smoking assessment on admission and quarterly; instruct resident on smoking protocol; keep smoking materials locked at nurse ' s station; provide designated smoking area for residents; monitor for continued safe smoking; provide scheduled staff supervised smoking times; and, redirect resident during non-smoking times.

Review of a Smoking Schedule provided upon entrance to the facility on 6/12/17 read, in part: "In order to endure resident safety, [Facility] has implemented scheduled smoking times..." The scheduled smoking times were listed as: 9:30 AM - 9:45 AM; 11:30 AM - 11:45 AM; 1:30 PM - 1:45 PM; 3:30 PM - 3:45 PM; and, 6:30 PM - 6:45 PM.

Review of a Smokers ' List provided upon entrance to the facility on 6/12/17 included 12 residents. Resident #119 was listed as a safe smoker. Only of the 12 residents listed was designated as an unsafe smoker.

An interview was conducted on 6/13/17 at 10:00 AM with Nursing Assistant (NA) #5. When asked what the facility ' s procedures were if the resident wanted to smoke at other times, the NA hesitated and shook her head. The NA indicated that situation had not come up in the past.

An interview was conducted on 6/14/17 at 2:45 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the

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Administrator reported that although the facility had designated smoking times, a resident could ask to smoke at another time and they would have a staff person go out with him/her for a smoking break. The Administrator confirmed a resident assessed to be a safe smoker was not allowed to go out by themselves to smoke.

An interview was conducted on 6/15/17 at 8:50 AM with Resident #119. During the interview, the resident acknowledged he was a smoker. Upon inquiry, Resident #119 stated the facility provided designated smoking times to "Go out 5 times a day," and he reported he typically did go out to smoke at each of the designated times. The resident reported he typically smoked 1 cigarette during each break, but noted he was limited to smoking no more than 2 cigarettes during a smoking break per facility protocol. When asked if he could go out to smoke at times other than the designated smoking times, the resident stated, "No, you ain't supposed to." When asked how he felt about it, the resident shrugged his shoulders and stated, "It's alright."

An interview was conducted on 6/15/17 at 9:44 AM with NA #6. NA #6 was supervising the smoking break in the designated smoking area. The smokers included Resident #119. Upon inquiry, NA #6 stated the designated smoking time was 15 minutes and only 2 cigarettes were allowed during each smoking break. When asked what happened if a resident wanted to smoke at a time other than a designated smoking time, she stated, "We have to take them."

An interview was conducted on 6/15/17 at 2:44 PM with the DON. Upon inquiry, the DON reported Resident #119 was a reliable historian.

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F 242	Continued From page 7 During a follow-up interview with the DON conducted on 6/15/17 at 3:00 PM, the DON reviewed Resident #119 ' s smoking assessment dated 3/10/17. Upon review, the DON confirmed the Quarterly Data Collection form indicated the resident was a safe smoker. A follow-up interview was conducted on 6/15/17 at 5:33 PM with the facility ' s Administrator regarding the smoking policy. Upon inquiry, the Administrator stated her expectation would be, "to follow the regulations."	F 242		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain 3 of 3 resident shower rooms (600 hall, 100 hall, 200 hall) in a safe and sanitary manner. The findings included: An observation of the 600 hall shower room on 06/13/2017 at 8:36 AM revealed that the shower room had an odor of feces and urine that permeated into the hallway of the 600 hall. Six cracked tiles were observed on the walls near the floor of the shower stall and dark black and rust colored grout throughout the tiles on the wall and floor throughout the shower room and shower stall. An observation of a dark brown smear was observed on the trash can lid.	F 253	F253 Housekeeping/Maintenance 1.) On 6/15/17, Housekeeping Supervisor cleaned 100, 200 and 600 hall shower rooms and removed trash and linens from floor and the Maintenance Director temporarily fixed cracked tiles. On 6/15/17, the Maintenance Director replaced the cracked thermostat and shower chair in the 100 hall shower room. By 7/13/17, the Maintenance Director replaced all cracked tiles identified and grout was deep cleaned and coated with a protective sealant. 2.)On 6/15/17, the Maintenance Director and Executive Director inspected facility	7/13/17

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F 253	Continued From page 8 An observation of the shower room on the 100 hall on 06/13/2017 at 9:02AM. Dirty linen was observed on the floor under the sink and paper and trash debris were observed on the floor throughout the shower room. The shower chair inside the shower stall was covered with dried yellow stained linens and residents personal clothing items. On 06/13/2017 at 9:11AM of the shower room on the 200 hall revealed the ½ shelf wall between the whirlpool tub and the shower stall had 1 chipped cracked tile which exposed sharp edges and 2 cracked, chipped tiles were observed on the outside corner of the half wall to the right of the entrance into the shower stall. Three cracked tiles were observed on the wall of the shower stall near the floor and the tile grout was dark black, rust red in color throughout the shower stall. On 06/14/2017 at 8:33AM, an observation of the shower room on the 600 hall revealed six cracked tiles were observed on the walls near the floor of the shower stall and dark black and rust colored grout throughout the tiles on the wall and floor throughout the shower room and shower stall. The trash can lid was observed to be clean. An observation of the shower room on the 100 hall was conducted on 06/14/2017 at 8:38 AM. There was no dirty linen observed in the shower room and no trash debris was observed on the floor. On 06/14/2017 at 9:11 an observation of the 200 hall shower room revealed the ½ shelf wall between the whirlpool tub and the shower stall had 1 chipped cracked tile which exposed sharp	F 253	shower rooms to ensure safe and sanitary conditions for residents. Follow up based on findings. 3)On 6/15/17, the Executive Director reeducated the Maintenance Director on performing routine maintenance inspections and repairs of the shower rooms to maintain a safe environment, free from accident hazards. On 6/15/17, the Director of Housekeeping reeducated housekeeping staff on performing routine housekeeping inspections and cleaning of the shower rooms to maintain a sanitary environment for residents. On 6/29/17, the Director of Clinical Services reeducated nursing staff on maintaining a safe environment, free from accident hazards and maintaining sanitary shower rooms by properly cleaning area after each use, disposing of trash in trash cans with closed lids, placing soiled linens in designated area, storing bath products and chemicals in locked cabinet and reporting to maintenance any areas needing repair and/or replacement. Newly hired maintenance, housekeeping and nursing staff will be educated upon hire. The Maintenance Director and/or designee to inspect shower rooms daily and upon request to ensure safe, well maintained conditions for residents, free from accident hazards. The Director of Housekeeping and/or designee to inspect shower rooms daily and deep clean weekly to ensure clean, sanitary conditions are maintained for residents. Nursing staff to maintain safe and sanitary shower rooms by properly cleaning area	

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F 253	Continued From page 9 edges and 2 cracked, chipped tiles were observed on the outside corner of the half wall to the right of the entrance into the shower stall. Three cracked tiles were observed on the wall of the shower stall near the floor and the tile grout was dark black, rust red in color throughout the shower stall. On 06/14/2017 at 9:30AM, an environmental tour was conducted with the facility administrator. The tour included an observation of the 600 hall shower room. The administrator was not aware of the cracked tiles in the shower stall or of the discolored grout surrounding areas of tile on the shower room and shower stall walls and floor. An environmental tour of the 100 hall shower room was conducted with the administrator on 06/14/2017 at 9:34 AM and revealed that there was no trash or dirty linen observed in the shower room. During the environmental tour with the facility administrator on 06/14/2017 at 9:42 AM revealed the administrator was not aware of the cracked thermostat cover on the wall or the cracked sharp edges from the tile on the ½ shelf. The administrator observed the cracked tiles on the shower stall walls with chipped, sharp edges on the corner post into the shower stall. The administrator also acknowledged that dark black and rust colored grout was visible around multiple tiles in the shower room. On 06/15/2017 at 9:03AM an observation of the shower room on the 100 hall revealed that all cracked, sharp edged tiles were covered with clear plexiglass.	F 253	after each use, disposing of trash in trash cans with closed lids, placing soiled linens in designated area, storing bath products and chemicals in locked cabinets, keeping shower room door locked with key pad and reporting to maintenance any areas needing repair and/or replacement immediately. 4)The Executive Director or designee to complete quality improvement monitoring of facility shower rooms to ensure safety, free from accident hazards and sanitary conditions are maintained. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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F 253	Continued From page 10 During an interview conducted with the administrator on 06/15/2017 at 2:00 PM the administrator stated that the facility was going to and fix the tiles in the shower rooms which had been covered with clear plexiglass temporarily. The administrator revealed that maintenance would complete more frequent rounds and report needed repairs to her to address immediately and that her expectation was that all repairs would be completed timely.	F 253		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		7/13/17

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain 3 of 3 resident shower rooms (600 hall, 100 hall, 200 hall) free from accident hazards. The findings included: An observation of the 600 hall shower room on 06/13/2017 at 8:36 AM revealed that the shower room door was propped open with a shower chair. There were 2 gallon sized bottles of body wash without lids on the floor and 3 gallon sized bottles of body lotion on the floor without lids next to the shower stall and whirlpool tub. The wall storage cabinet was unlocked and contained an opened spray bottle of Bleach germicidal cleaner. An observation of the shower room on the 100 hall on 06/13/2017 at 9:02 AM revealed that the key pad lock was not secured to lock the shower room door and the door opened freely. The mounted storage cabinet was unlocked and contained an opened spray bottle of Vivex 2 256 disinfectant cleaner and 3 bottles of deodorant were inside the cabinet. On 06/13/2017 at 9:11 AM of the shower room on the 200 hall revealed the key pad lock on the exterior of the shower room door was unlocked and the thermostat cover located on the left wall had a cracked cover that exposed 2 batteries taped in place. The wall storage cabinet mounted on the wall to the right of the commode had an opened spray bottle of Vivex 2 256 on the top of the cabinet. On 06/14/2017 at, 8:30 AM an observation of the	F 323	F323 Free from Accident Hazards 1)On 6/15/17, the Maintenance Director replaced the thermostat in the 200 hall shower room. Shower rooms continue to be free from accident hazards by ensuring doors are locked with key pad access, storing chemicals and bath products with lids in locked cabinets and performing routine maintenance. 2)On 6/15/17, the Maintenance Director and Executive Director inspected facility shower rooms to ensure a safe environment free from accident hazards for residents. Follow up based on findings 3)On 6/15/17, the Executive Director reeducated the Maintenance Director on performing routine maintenance inspections and repairs of the shower rooms to maintain a safe environment, free from accident hazards. On 6/29/17, the Director of Clinical Services reeducated nursing staff on maintaining a safe environment, free from accident hazards by storing bath products and chemicals with lids in locked cabinets, keeping shower room doors locked with key pad and reporting to maintenance any areas needing repair and/or replacement immediately. Newly hired maintenance and nursing staff to be educated upon hire. The Maintenance Director and/or designee to inspect shower rooms daily and upon request to ensure safe, well	

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F 323	Continued From page 12 shower room on the 600 hall revealed that the shower room door was propped open with a shower chair and the wall mounted storage cabinet was unlocked and contained an opened spray bottle of Bleach germicidal cleaner was inside of the cabinet. There were no opened body wash or body lotion observed in the shower room. An observation of the shower room on the 100 hall was conducted on 06/14/2017 at 8:38 AM and revealed that the shower room door was not securely locked by the door key pad lock. The mounted storage cabinet was unlocked and contained an opened spray bottle of Vivex 2 256 disinfectant cleaner and 3 bottles of deodorant were inside the cabinet. On 06/14/2017 at 9:11 AM, an observation of the 200 hall shower room revealed that the shower room door was not securely locked with the door key pad lock and that the wall mounted thermostat cover was cracked and tape was used to secure 2 batteries in the thermostat. The wall storage cabinet mounted on the wall to the right of the commode had an opened spray bottle of Vivex 2 256 on the top of the cabinet. On 06/14/2017 at 9:30AM, an environmental tour was conducted with the facility administrator. The tour included an observation of the 600 hall which was locked by the door key pad lock and that there was an opened spray bottle of Bleach germicidal cleaner inside of the cabinet. The administrator was not aware that the wall cabinet had been unlocked and contained a bleach cleaner or that the shower room door had been propped open with a shower chair. An environmental tour of the 100 hall shower room was conducted with the administrator on	F 323	maintained conditions, free from accident hazards. Nursing staff to maintain a safe environment, free from accident hazards in shower rooms by storing bath products and chemicals with lids in locked cabinets, keeping shower room doors locked with key pad and reporting to maintenance any areas needing repair and/or replacement immediately. 4)The Executive Director to complete quality improvement monitoring of facility shower rooms to ensure a safe environment, free from accident hazards is maintained. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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F 323	Continued From page 13	F 323		

06/14/2017 at 9:34 AM and revealed that the door to the shower room was securely locked by the door key pad lock. The mounted storage cabinet was unlocked and contained an opened spray bottle of Vivex 2 256 disinfectant cleaner and 3 bottles of deodorant inside the cabinet.

During the environmental tour with the facility administrator on 06/14/2017 at 9:42 AM, the door to the 200 hall shower room was securely locked by the door key pad lock and the administrator was not aware of the cracked thermostat cover on the wall or of the unlocked wall mounted cabinet with an opened spray bottle of Vivex 2 256 disinfectant cleaner being stored on the top of the cabinet.

On 06/15/2017 at 9:03 AM an observation of the shower room doors of the shower rooms on the 600 hall, 100 hall and 200 hall were all securely locked and that the wall mounted cabinets had been secured and locked. The thermostat cover in the 200 hall shower room had not been repaired.

During an interview conducted with the administrator on 06/15/2017 at 2:00 PM the administrator stated that the staff was expected to lock the exterior doors of the shower rooms tightly by pulling on the exterior door handles to check that the doors would not open without pressing they key pad lock codes and that the wall mounted cabinets were to be locked when not in use and that there were not be any chemicals or resident care items stored in unlocked cabinets or on the floors of the shower rooms. The administrator revealed that the thermostat cover in the 200 hall shower room would be replaced immediately and that the

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F 323	Continued From page 14 maintenance director would conduct more frequent environmental rounds and report to the administrator any repairs that needed to be made.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		7/13/17

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F 329	Continued From page 15 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to monitor a resident ' s blood pressure as ordered by the physician prior to administering a blood pressure medication for 1 of 6 sample residents (Resident #21) reviewed for unnecessary medications. The findings included: Resident #21 was admitted to the facility on 1/17/17. His cumulative diagnoses included atherosclerotic heart disease. A review of Resident #21 ' s most recent quarterly Minimum Data Set (MDS) dated 5/1/17 revealed the resident was assessed to be cognitively intact. He required supervision for all of his Activities of Daily Living (ADLs). A review of Resident #21 ' s current care plan (revised on 5/1/17) included a focus area on the topic of "Cardiovascular." The care plan interventions included the following, in part: --Vital signs as ordered and as needed; --Medications as ordered; --Hypo/hypertension (low and high blood pressure) and syncope (temporary loss of consciousness caused by a fall in blood pressure) and notify physician as needed. A review of Resident #21 ' s May 2017 and June	F 329	F329 Free from Unnecessary Drugs 1)On 6/13/17, the licensed nurse notified the physician of resident #21 blood pressure monitoring that was not being completed as ordered for a antihypertensive medication. Resident #21 will continue to have blood pressure monitoring as ordered. 2)On 6/13/17, Director of Clinical Services identified residents with blood pressure monitoring orders to ensure licensed nurses are documenting blood pressures as orders. Any discrepancies identified were reported to the physician by the licensed nurse and new orders followed as appropriate. 3)On 6/29/17, the Director of Clinical Services reeducated licensed nurses on the company policy of following physicians orders and completing blood pressure monitoring as ordered and to further prevent the use of unnecessary drugs. Newly hired licensed nurses will be educated upon hire. The licensed nurse to follow physicians' orders regarding blood pressure monitoring and document on the MAR (Medication Administration Record) as indicated.	

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F 329	Continued From page 16 2017 physician orders included a current order for 30 milligrams (mg) isosorbide mononitrate ER (an extended release antianginal medication used to manage chest pain) to be given as one tablet by mouth every morning. The physician ' s medication order also included instructions to "Hold if SBP (systolic blood pressure) less than 110." The isosorbide mononitrate ER was scheduled to be administered at 9:00 AM each day. A review of Resident #21 ' s May 2017 Medication Administration Record revealed blood pressure results were documented on 6 out of 31 days during the month (5/8/17, 5/11/17, 5/13/17, 5/14/17, 5/15/17 and 5/16/17). A review of Resident #21 ' s June 2017 Medication Administration Record from 6/1/17 through the date of the review (6/13/17) revealed no blood pressure results were documented. An interview was conducted on 6/13/17 at 11:50 AM with Nurse #3. Nurse #3 was the 1st shift nurse assigned to care for Resident #21 and was observed to administer Resident #21 ' s morning dose of isosorbide mononitrate ER during the Medication Administration Observation earlier that morning. During the interview, the nurse was asked what the resident ' s blood pressure was prior to the medication administration. Nurse #3 reported the nursing assistants had taken the resident ' s blood pressure and had given him a note with the results. Nurse #3 recalled Resident #21 ' s blood pressure was 118/74 that morning, but was not sure what time it had been taken. When asked to see the note documenting the blood pressure result, the nurse stated he did not have it.	F 329	4)The Director of Clinical Services to complete quality improvement monitoring of residents with blood pressure monitoring orders to ensure compliance to prevent unnecessary drugs. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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F 329	Continued From page 17 An interview was conducted on 6/15/17 at 12:00 PM with the facility ' s Director of Nursing (DON). During the interview, inquiry was made as to where blood pressure results were documented. The DON reported blood pressure results should be recorded on the resident ' s MAR. Upon review of the MAR, the DON confirmed only 6 blood pressure results were noted on the May 2017 MAR and no blood pressure results were recorded on the June 2017 MAR. The DON also reviewed a binder kept at the Nursing Station (referred to as a Hot Box). However, no blood pressure results were documented in the binder. When asked, the DON reported that as long as the parameters were written as part of the medication order, she would expect the nurse to take the resident ' s blood pressure to ensure it was within the parameters given prior to administration of the isosorbide mononitrate ER. An interview was conducted on 6/15/17 at 12:30 PM with the resident ' s physician (who also served as the facility ' s Medical Director). During the interview, the resident ' s medical records and the missing blood pressure readings were discussed. Upon inquiry, the physician stated if an order included blood pressure parameters for a medication, he would expect the resident ' s blood pressure to be taken prior to the medication administration. A follow-up interview was conducted on 6/15/17 at 1:00 PM with Nurse #3. Upon inquiry, Nurse #3 reported Resident #21 ' s blood pressure results should be documented on the MAR.	F 329		
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		7/13/17

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F 332	Continued From page 18 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by 4 medication errors out of 25 opportunities, resulting in a medication error rate of 16% for 2 of 3 residents (Resident #21 and Resident #103) observed during medication pass. The findings included: 1) On 6/13/17 at 10:35 AM to 11:10 AM, Nurse #3 was observed as he prepared and administered medications to Resident #21. The administered medications included 12.5 mg carvedilol (an antihypertensive medication) given as 1 tablet by mouth. A review of Resident #21 ' s June 2017 physician ' s medication orders included a current order 12.5 mg carvedilol to be given as 1 tablet by mouth twice daily (scheduled for 9:00 AM and 5:00 PM). An interview was conducted on 6/13/17 at 11:25 AM with Nurse #3. During the interview, the nurse reported morning medications were typically administered around 10:00 AM for Resident #21 ' s hallway. He stated this was the last of the three hallways where he was assigned to administer morning medications.	F 332	F332 Med Error Rate >5% 1)On 6/13/17, the licensed nurse notified the physician that resident #21 was not administered the right medications at the right time and in the right form. No new orders received and resident will continue to receive the correct medications as ordered at the right time and in the right form. On 6/13/17, the licensed nurse notified the physician that resident #103 was not administered a medication in the right form. No new orders were received and resident will continue to receive medications as ordered in the right form. 2)On 6/27/17, the pharmacy consultant completed a medication review of medication carts to ensure that the right medications, doses and forms were available as ordered by the physician. On 6/29/17, the Director of Clinical Services reviewed medication carts to ensure that the right medications, doses and forms are available as ordered by the physician, as well as, a review of medication pass times to ensure nurses ability to administer medications at the time ordered within the hour before or hour after parameter.	

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F 332	Continued From page 19 An interview was conducted on 6/14/17 at 1:00 PM with Resident #21. Upon inquiry, the resident reported he typically received his morning medications from the nurse around 11:00 each day. When asked if he ever felt light-headed when he got up from a sitting to standing position, the resident stated, "Oh yeah." However, the resident could not identify any specific time of the day when this occurred. The resident reported that prior to coming to the facility in January, he took his medications at 8:00 AM and 6:00 PM daily. A review of Resident #21 ' s most recent quarterly Minimum Data Set (MDS) assessment (dated 5/1/17) revealed the resident had intact cognitive skills for daily decision making. An interview was conducted on 6/15/17 at 12:30 PM with the resident ' s physician. During the interview, the 2-hour delay of Resident #21 ' s morning medications was discussed. The physician indicated Resident #21 ' s baseline status included some light-headedness at times. Upon further inquiry, the physician stated he would typically order carvedilol given twice daily with the doses spaced 10-12 hours apart. An interview was conducted on 6/15/17 at 2:47 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect medications to be administered within one hour of the scheduled administration time. 2) On 6/13/17 at 10:35 AM to 11:10 AM, Nurse #3 was observed as he prepared and administered medications to Resident #21. The administered medications included 20 milligrams (mg) torsemide (a diuretic) given as two tablets by mouth.	F 332	3)On 6/29/17, the Director of Clinical Services reeducated licensed nurses on administering medications as ordered per company policy and the five rights of medication administration including; the right patient, the right drug, the right dose, the right route and the right time (within the parameters of one hour before or after scheduled time). Newly hired licensed nurses to be educated upon hire. The licensed nurse to administer medications as ordered to the right resident, the right drug, the right dose, the right route and the right time within the parameters of one hour before or after scheduled time. Any discrepancies to be reported to the physician by the licensed nurse and new orders followed as indicated. 4)The Director of Clinical Services to complete quality improvement monitoring of 3 random residents medication pass to ensure administration as ordered. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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A review of Resident #21 ' s June 2017 physician ' s medication orders included a current order for 20 mg torsemide to be given as two tablets by mouth once daily (scheduled for 9:00 AM).

An interview was conducted on 6/13/17 at 11:25 AM with Nurse #3. During the interview, the nurse reported morning medications were typically administered around 10:00 AM for Resident #21 ' s hallway. He stated this was the last of the three hallways where he was assigned to administer morning medications.

An interview was conducted on 6/14/17 at 1:00 PM with Resident #21. Upon inquiry, the resident reported he typically received his morning medications from the nurse around 11:00 each day. The resident stated the torsemide (diuretic) medication usually "kicked in" about two hours after taking it, which was typically right after lunch or just before activities started in the afternoon. When asked if it would work out better for him to take the diuretic at 9:00 AM (instead of 11:00 AM) so the medication could take effect around 11:00 AM, the resident stated it would. A review of Resident #21 ' s most recent quarterly Minimum Data Set (MDS) assessment (dated 5/1/17) revealed the resident had intact cognitive skills for daily decision making.

An interview was conducted on 6/15/17 at 12:30 PM with the resident ' s physician. During the interview, the 2-hour delay of Resident #21 ' s morning medications was discussed. The physician stated that if the resident ' s quality of life was affected by the delay of torsemide administration, he would advocate it be given earlier in the morning as scheduled.

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An interview was conducted on 6/15/17 at 2:47 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect medications to be administered within one hour of the scheduled administration time.

3) On 6/13/17 at 10:35 AM to 11:10 AM, Nurse #3 was observed as he prepared and administered medications to Resident #21. The administered medications included a combination medication containing 50 mg docusate with 8.6 mg sennosides (a stool softener and bowel stimulant medication) given as two tablets by mouth.

A review of Resident #21 ' s June 2017 physician ' s medication orders included a current order for 8.6 mg sennosides to be given as two tablets by mouth twice daily.

An interview was conducted on 6/13/17 at 11:25 AM with Nurse #3. Upon request, the nurse reviewed Resident #21 ' s Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the combination docusate/sennosides tablets given to the resident. The nurse confirmed the medication ordered and indicated by the MAR was not the same as the combination medication administered to Resident #21.

An interview was conducted on 6/15/17 at 2:47 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nursing staff to give the correct medication and dosage form as ordered by the physician.

4) On 6/13/17 at 8:45 AM to 8:55 AM, Nurse #2

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F 332	Continued From page 22 was observed as she prepared and administered medications to Resident #103. The administered medications included an 81 milligram (mg) enteric coated aspirin given as one tablet by mouth. A review of Resident #103 ' s June 2017 physician ' s medication orders included a current order for one-81 mg chewable aspirin to be given once daily. An interview was conducted on 6/13/17 at 1:50 PM with Nurse #2. Upon request, the nurse reviewed Resident #103 ' s Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the 81 mg aspirin tablet given to the resident. The nurse confirmed the medication ordered and indicated by the MAR was not the same dosage form as the medication administered to Resident #103. An interview was conducted on 6/15/17 at 2:47 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nursing staff to give the correct medication and dosage form as ordered by the physician.	F 332		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;	F 411		7/13/17

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F 411	Continued From page 23 (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to arrange an appointment with the dentist as ordered for 1 of 3 residents reviewed for dental services, Resident #84. Findings included: Resident #84 was admitted to the facility on 05/26/16 and readmitted to the facility on 05/25/17 with diagnoses that included: Heart failure, hypertension and diabetes. On 02/07/17, Resident #84 had a dental evaluation. Dentist oral exam notes revealed Resident #84's soft tissues were red, inflamed with lower ridge appearing flat. Dentist recommended that the resident remove dentures nightly and clean daily. At the time of the dental exam, resident was asymptomatic with no pain and revealed the resident ate well. According to the exam notes, no immediate restorative needs for replacing resident's dentures were necessary. On 04/18/17, a physician order had been written	F 411	F411 Dental Services 1)On 6/14/17, the licensed nurse notified the physician of resident #84 missed dental appointment and received new orders to reschedule. Resident #84 received dental services on 6/20/17 and will receive new dentures once dentures are made. 2)On 7/7/17 , Licensed Nurse Re-evaluated residents' dental status to ensure dental services are scheduled and provided as ordered. 3)On 7/6/17, the Director of Clinical Services Re-educated licensed nurses and social workers on the process of ensuring residents receive routine and emergency dental services as ordered. The licensed nurse will assess residents' dental status upon admission, readmission, and quarterly and with significant changes in condition and notify physician of routine and emergency dental	

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F 411	Continued From page 24 to arrange an appointment with Resident #84's dentist to replace dentures. The orders stated the resident would provide the name and address of dentist. Resident #84's Annual Minimum Data Set (MDS) dated 05/18/17 revealed the resident was cognitively intact and able to make her needs known. The MDS revealed resident #84 had loosely fitting dentures with no weight loss or weight gain concerns noted. Medical records revealed an appointment had been scheduled with the facility's contract dentist for resident to be seen on 05/23/17 at 9:00 AM. The Care Plan for Resident #84 dated 06/09/17 revealed resident required supervision for eating and setup help for oral hygiene. Concerns and risks related to resident's "loose dentures" were addressed to include monitoring for risks related to potential fluid imbalance, imbalanced nutrition, diuretic use, dehydration, weight fluctuation and possible chewing difficulties. Care plan goals revealed the resident was to have no complications related to "loose dentures" through the next review period. A resident interview on 06/12/17 at 11:36 AM revealed Resident #84 wanted new dentures because her current dentures no longer fit well. Review of resident's Meal Intake Detail Report dated 05/18/17 through 06/15/17 revealed Resident #84 consumed between 75%-100% daily of all meals (breakfast, lunch and dinner). An interview was conducted with the Social Services Director (SSD) on 06/14/17 at 3:04 PM.	F 411	needs. Upon receipt of dental service orders, the licensed nurse will notify the social worker who will be responsible for coordinating the scheduling and transportation needs. Missed appointments to be reported to the physician and rescheduled as appropriate. Newly hired licensed nurses and social workers to be educated upon hire. 4)The Social Service Designee To complete quality improvement monitoring of 5 random residents' dental status to ensure outside dental services are provided as necessary. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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SSD stated she had not been informed of Resident #84 needing or wanting dentures. The SSD stated the facility had an in-house dentist that came to the facility and mentioned the resident would not normally be "sent out" to see another dentist unless there was a major concern or the resident had been referred to someone else by the in-house dentist.

An interview was conducted with Resident #84 on 06/15/17 at 3:27 PM. Resident #84 stated she had spoken with the SSD today (06/15/17) about getting new dentures.

An interview with the MDS Nurse #2 conducted on 06/15/17 at 5:01 PM revealed she was aware of an order written by the physician to schedule Resident #84's dental appointment to replace her dentures. She stated the SSD had emailed her and mentioned the resident had been in the hospital and missed her last dental appointment. The MDS Coordinator stated she sent an email to the SSD on 06/08/17 informing her Resident #84's dentures were loose. The SSD sent an email back to the MDS coordinator stating: "thanks for letting me know." Emails were provided to surveyor by MDS coordinator. A follow-up appointment had never been rescheduled after the resident's hospitalization.

An interview was conducted with the facility's Administrator on 06/15/17 at 6:19 PM. The Director of Nursing was also in attendance. The Administrator stated she expected staff to follow-up on all appointments for all residents. The Administrator stated in the case of follow-up appointments for the dentist, she would go ahead and schedule outside dental appointments and not have the resident wait on the return of the

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F 411	Continued From page 26 facility's dentist.	F 411		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		7/13/17

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F 431	Continued From page 27 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility: 1) Failed to date medications with shortened expiration dates and to discard expired medications on 3 of 3 medication carts observed (405 Down Medication Cart, 400/500 Medication Cart, and 100-204 Medication Cart); and, 2) Failed to store medications in accordance with the manufacturer's recommendations in 2 of 3 medication carts observed (100-204 Medication Cart and 405 Down Medication Cart). The findings included: 1a) An observation of the 405 Down Medication Cart conducted on 6/14/17 at 9:03 AM revealed an opened Novolog insulin pen labeled for Resident #75 had a hand-written date of 4/5/17 on the pen. A review of the manufacturer ' s storage instructions indicated prefilled pens that have been punctured (in use) should be used within 28 days. The calculated expiration date of	F 431	F431 Drug Labeling, Storage and Disposal 1)On 6/14/17, the licensed nurse disposed of identified undated medications with shortened expiration dates and expired medication on 405 down, 400/500 and 100-204 medication carts and disposed of identified medications not stored per manufacturer’s recommendations on the 100-204 and 405 down medication carts. 2)On 6/22/17 & 6/29/17, the licensed nurses monitored medication carts and medication rooms and central supply storage rooms to ensure medications, including medications with shortened expiration dates are properly dated, disposed of and stored per manufacturers recommendations.	

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F 431	Continued From page 28 the Novolog insulin pen stored on the med cart for Resident #75 was 5/3/17. A review of Resident #75 ' s June 2017 Physician Order Summary revealed there was a current order for Novolog insulin to be used twice daily as sliding scale insulin (SSI). SSI coverage indicated that the dose of insulin administered was dependent on the resident's blood sugar (BS) result. An interview was conducted on 6/14/17 at 9:05 AM with Nurse #1. During the interview, the nurse reported insulin expiration dates were in listed in the Medication Administration Record (MAR) binder. Upon review, the nurse stated the Novolog insulin pen was only good for 28 days. She stated, "This is trash." An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications. She stated a medication should have an expiration date on it and the expiration date needed to be adhered to. 1b) An observation of the 400/500 Medication Cart conducted on 6/14/17 at 8:50 AM revealed 13 vials of 0.5 milligrams (mg) / 3 mg ipratropium / albuterol inhalation solution (a combination medication used via a nebulizer for the management of chronic obstructive pulmonary disease) were stored inside of the manufacturer ' s box (outside of the foil pouch). The vials were not dated as to when they had been removed from the foil pouch. The box of ipratropium / albuterol solution was dispensed for Resident #109 on 5/8/17. The manufacturer ' s product	F 431	3)On 6/29/17, the Director of Clinical Services reeducated licensed nurses on the proper storage, labeling and disposal of expired medications. Education included following manufacturers recommendations printed on individual packaging for storage indications, labeling medications with shortened expiration dates upon initial use with “open on/expire on” dates and proper disposal of expired medications. Newly hired licensed nurses to be educated upon hire. The licensed nurse to follow manufacturers recommendations printed on individual packaging for storage indications, label medications with shortened expiration dates upon initial use with “open on/expire on” dates and properly dispose of expired medications during his/her medication pass. The nurse supervisors to quality monitor med carts and medication rooms weekly for compliance. The pharmacy consultant to quality monitor medication carts and medication rooms monthly for compliance. 4)The Director of Clinical Services or designee to complete quality improvement monitoring of medication carts and medication rooms to ensure the proper storage, labeling and disposal of medications. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness	

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F 431	Continued From page 29 labeling on the package of the ipratropium / albuterol solution provided the following storage instructions which read, in part: " ... Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week." A review of Resident #109 ' s June 2017 Physician ' s Order Summary revealed the resident had a current order for one vial of ipratropium / albuterol inhalation solution to be used every four hours as needed for wheezing. A review of the resident ' s June 2017 Medication Administration Record revealed only 3 vials of the inhalation solution had been used for Resident #109 during the month up to the date of the review. An interview was conducted on 6/14/17 at 8:55 AM with Nurse #3. During the interview, the nurse reported the 13 vials of ipratropium / albuterol sulfate solution should have been stored in a dated foil pouch. Nurse #3 stated, "I ' m going to order new medication, they ' re too old." An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications. She stated a medication should have an expiration date on it and the expiration date needed to be adhered to. The DON also stated if a pouch of a nebulizer solution pouch was opened, the vials should be stored in the pouch and the pouch dated as to when it had been opened so the staff would know when it expired.	F 431	of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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1c) An observation of the 400/500 Medication Cart conducted on 6/14/17 at 8:50 AM revealed 4 vials of 0.5 milligrams (mg) / 3 mg ipratropium / albuterol inhalation solution (a combination medication used via a nebulizer for the management of chronic obstructive pulmonary disease) were stored inside of the manufacturer ' s box (outside of the foil pouch). The vials were not dated as to when they had been removed from the foil pouch. The box of ipratropium / albuterol solution was dispensed for Resident #45 on 4/29/17. The manufacturer ' s product labeling on the package of the ipratropium / albuterol solution provided the following storage instructions which read, in part: " ... Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week."

A review of Resident #45 ' s June 2017 Physician ' s Order Summary revealed the resident had a current order for one vial of ipratropium / albuterol inhalation solution scheduled to be used every four hours daily.

An interview was conducted on 6/14/17 at 8:55 AM with Nurse #3. During the interview, the nurse reported the 4 vials of ipratropium / albuterol sulfate solution should have been stored in a dated foil pouch. Nurse #3 stated, "I ' m going to order new medication, they ' re too old."

An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications. She stated a medication should have an expiration date on it

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and the expiration date needed to be adhered to. The DON also stated if a pouch of a nebulizer solution pouch was opened, the vials should be stored in the pouch and the pouch dated as to when it had been opened so the staff would know when it expired.

1d) An observation of the 100-204 Medication Cart conducted on 6/14/17 at 9:40 AM revealed an opened bottle of Memory Guard dietary supplement did not have an expiration date on the bottle. The bottle of dietary supplement had hand-written notations which indicated the bottle was intended for use by Resident #159 and was noted as opened on 1/21/17.

A review of Resident #159 ' s June 2017 Physician Order Summary revealed there was a current order (dated 3/9/17) for "Miscellaneous," with instructions to give 1-Memory Guard daily with breakfast. The order noted the resident ' s family provided the dietary supplement.

An interview was conducted on 6/14/17 at 9:44 AM with Nurse #4. Upon inquiry, the nurse confirmed no expiration date was noted on the bottle. When asked what she thought about this, the nurse stated she was not comfortable administering a medication that did not have an expiration date on it.

An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect a medication to have an expiration date on it and for the expiration date to be adhered to.

2a) An observation of the 100-204 Med Cart was conducted on 6/14/17 at 9:40 AM. The

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observation revealed
3 vials of 0.083% albuterol inhalation solution (a medication used via a nebulizer for the management of asthma and chronic obstructive pulmonary disease) were stored lying outside of both the manufacturer ' s box and the opened, undated foil pouch. The box of albuterol solution was dispensed for Resident #2 on 5/1/17. The manufacturer ' s product labeling on the package of the albuterol solution provided the following storage instructions which read, in part: "protect from light."

A review of Resident #2 ' s June 2017 Physician Order Summary revealed there was a current order for the contents of one vial of 0.083% albuterol inhalation solution to be given per nebulizer every 4-6 hours as needed for wheezing.

An interview was conducted on 6/14/17 at 9:44 AM with Nurse #4. Upon review of the labeling, Nurse #4 indicated the vials of albuterol inhalation solution needed to be stored as indicated by the manufacturer.

An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications.

2b) An observation of the 405 Down Medication Cart conducted on 6/14/17 at 9:03 AM revealed 3 vials of 0.5 milligrams (mg) / 3 mg ipratropium / albuterol inhalation solution (a combination medication used via a nebulizer for the management of chronic obstructive pulmonary disease) were stored partially outside of an

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opened pouch and exposed to light. Five (5) additional vials of solution were stored in an opened pouch and exposed to the light in the opened manufacturer ' s box. The box of ipratropium / albuterol solution was dispensed for Resident #148 on 5/8/17; a handwritten notation on the box indicated the box was opened on 6/3/17. The manufacturer ' s product labeling on the ipratropium / albuterol solution provided the following storage instructions which read, in part: "Protect from light. Unit-dose vials should remain stored in the protective foil."

A review of Resident #148 ' s June 2017 Physician Order Summary revealed there was a current order for ipratropium / albuterol inhalation solution to be inhaled as 1 vial via nebulizer four times daily for wheezing and shortness of breath and every 4 hours as necessary for shortness of breath.

An interview was conducted on 6/14/17 at 9:05 AM with Nurse #1. During the interview, the nurse reviewed the manufacturer ' s storage instructions and acknowledged the vials were not in the protective pouch to protect them from light, as indicated.

An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications.

2c) An observation of the 100-204 Med Cart was conducted on 6/14/17 at 9:40 AM. The observation revealed 1 - 5 milliliter (ml) bottle of 0.1% fluorometholone ophthalmic suspension (a corticosteroid suspension used as an eye drop)

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F 431	Continued From page 34 dispensed for Resident #137 on 6/1/17 was stored laying down on its side in a drawer of the medication cart. The manufacturer ' s instructions for storage were covered by the pharmacy labeling. Upon peeling back the pharmacy label, the manufacturer ' s labeling on the bottle of the ophthalmic suspension became visible and read, in part: "Store in upright position." A review of Resident #137 ' s June 2017 Physician Order Summary revealed there was an order (dated 6/1/17) for 0.1% fluorometholone ophthalmic suspension to be instilled as one drop in the right eye four times daily for 1 week. An interview was conducted on 6/14/17 at 9:44 AM with Nurse #4. Upon review of the labeling, Nurse #4 stated she was not aware the manufacturer storage requirements and indicated the eye drops needed to be stored upright. An interview was conducted on 6/14/17 at 3:25 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect manufacturer storage instructions to be followed for the medications.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		7/13/17

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communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 441	Continued From page 36 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow hand washing protocol after providing care to residents under special enteric contact isolation precautions for 2 of 3 residents (Resident #126 and Resident #6). Findings included: A review of the facility policy and procedures for isolation precautions revealed the facility used two tiers of isolation practices as recommended by the Center for Disease Control. First tier was standard precautions and second tier was airborne, droplet and contact precautions. The policy specified that the second tier of isolation precautions were to be used with patients who were known or suspected to be infected with highly transmissible or epidemiologically pathogens that could be transmitted by airborne or droplet transmission, or by contact with dry	F 441	F441 Infection Control 1)Resident #6 remains on enteric isolation precautions for Clostridium Difficile and did not experience harm from improper handwashing. Resident #126 has discharged home from the facility on 6/14/17. On 6/14/17, the Director of Clinical Services provided 1:1 reeducation to nurse aide #1, 2 and 3 and nurse #1 on following the enteric isolation precautions of washing hands with warm soap and water before leaving residents' room to prevent the spread of communicable infections. 2)On 6/22/17, licensed nurses re-evaluated residents for signs and symptoms of Clostridium Difficile and no additional residents were identified.	

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F 441	Continued From page 37 skin or contaminated surfaces. The policy specified hand washing equipment to be available for all isolation rooms. A review of the contact precautions: ' special enteric ' signage used on the door of isolation rooms revealed the signs to read, in part, "perform hand hygiene before entering room and wash hands with soap and water before leaving room." Resident #126 and # and #6 were on contact precautions for Clostridium difficile (C. diff), a highly contagious bacterial infection. C. diff is spread by spores from feces, and causes diarrhea and fever. The C. diff spores can be spread by touching a contaminated item and then touching mucus membranes. An observation of Resident #126 and #6 rooms was conducted on 6/14/2017 at 12:47 PM and signs for contact precautions: ' special enteric ' were posted on Resident #126 and #6 doors. Also seen were caddies with personal protection equipment (PPE), located on their doors and a shared bathroom with a sink, soap dispenser and paper towels for hand washing. Nursing assistant (NA) # 1 was observed applying gloves to deliver a lunch tray on 6/12/2017 at 12:47 PM to Resident #6. She removed the gloves prior to exiting the room, and left Resident #6 ' s room without washing her hands. She walked up the hallway to the eyewash station, used the passcode to enter the room. She exited the room rubbing her hands together. NA # 1 was observed applying gloves to deliver a lunch tray on 6/12/2017 at 12:51 PM to Resident #126. She removed the gloves after delivery of the tray to Resident #126, and left the room without washing her hands. She walked up the	F 441	3)On 6/14/17 & 6/29/17, the Director of Clinical Services and Executive Director reeducated facility staff on preventing the spread of infections by proper handwashing. Education for enteric isolation precautions included washing of hands with warm soap and water prior to leaving residents' room. Newly hired staff to be educated upon hire. Residents with orders for enteric isolation to have visual signage on the outside of their room door, along with appropriate PPE equipment available to staff to prevent the spread of communicable infections. Staff to wash hands with warm soap and water before leaving residents rooms when caring for residents on enteric isolation. Visitors to receive education regarding infection control practices for residents on enteric isolations precautions. Each family member after receiving education will sign acknowledgment of protocol. 4)The Director of Clinical Services or designee to complete quality improvement monitoring of residents on enteric isolation for appropriate handwashing practice. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary.	

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hallway to the eyewash station, used the passcode to enter the room. She was stopped as she exited and she stated she had washed her hands in the eye wash station.

NA #2 was observed on 6/14/2017 at 9:28 AM. She applied a gown to cover her clothing and applied gloves. Upon exiting Resident #126 ' s room, she had removed her gloves and gown and discarded those items in the trashcan located by the door, but was not observed to wash her hands. NA #2 exited the room and walked up the hall to the pantry, entered the code for the door and washed her hands in the pantry.

An observation was made on 6/14/2017 at 1:14 PM of Nurse #3 and NA #3. Nurse #3 was outside of Resident #6 ' s room dressed in a gown with gloves on his hands. NA #3 was exiting the room and did not have a gown or gloves on. She stated to Nurse #3 "I ' m going to wash my hands," and entered the passcode for the pantry door. NA #3 was stopped, taken back to the room to read the precautions sign on Resident #6 ' s room, which read, in part, "perform hand hygiene before entering room and wash hands with soap and water before leaving room". The NA read the signage aloud.

NA #1 was interviewed on 6/12/2017 at 12:47 PM. She reported she was the aide assigned to Resident #126 and #6. She reported she did not wash her hands in the room because she was trying to get out of the room quickly. The NA was asked to read the contact precautions sign: "perform hand hygiene before entering room and wash hands with soap and water before leaving room." She reported she did not wash her hands in the resident ' s room.

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NA #2 was interviewed on 6/12/2017 at 9:40 AM. She was asked to read the signage on the door, "Perform hand hygiene before entering room and wash hands with soap and water before leaving room." NA #2 reported she did not know she should wash her hands in the resident ' s room prior to exiting.

Nurse #3 was interviewed on 6/14/2017 at 10:41 AM. He reported the correct steps for entering and exiting an isolation room with enteric precautions. He reported if he witnessed a staff member who exited an isolation room without washing their hands with soap and water, he would stop and correct them.

Nurse #3 and NA #3 were interviewed on 6/14/2017 at 1:14 PM. NA #3 reported she did not wash her hands in Resident #6 ' s bathroom prior to exiting the room because Nurse #3 was washing his hands in the bathroom. Nurse #3 reported he was not aware the aide did not wash her hands in the bathroom prior to exiting.

The Administrator and Director of Nurses (DON), as well as the Regional DON were interviewed on 6/14/2017 at 4:25 PM. The Administrator, DON and Regional DON were unaware staff were exiting the isolation rooms without washing their hands.

A follow up interview was conducted on 6/15/2017 at 3:08 PM with the Administrator, DON and Regional DON. They reported they had provided education to NA #1, #2 and #3, as well as Nurse #3 on 6/14/2017. The Regional DON reported the staff had been trained on infection control and isolation, but that the staff may have been

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F 441	Continued From page 40 nervous during the observations and forgotten to wash their hands prior to exiting the room. The Regional DON further reported a root cause analysis had been performed and the results were to move the trash can from beside the door in the resident ' s isolation room to the bathroom. Staff would enter the bathroom to remove PPE and then be reminded to wash their hands prior to exiting the room.	F 441		
F 514 SS=F	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 514		7/13/17

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F 514	Continued From page 41 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store residents' care plans in a location readily accessible for use by the direct care staff on 6 of 6 residence halls (100 Hall, 200 Hall, 300 Hall, 400 Hall, 500 Hall, and 600 Hall). The findings included: An interview was conducted on 6/14/17 at 3:40 PM with Nurse #1. Upon inquiry as to where residents' care plans were kept for staff reference, the nurse stated they were kept in the MDS office (referring to an office where nurses worked on residents ' Minimum Data Set or MDS assessments). The MDS office was located at the end (opposite from the nursing station) of one of the residents ' hallways. An interview was conducted on 6/14/17 at 3:45 PM with Nurse #5. Upon inquiry as to where residents' care plans were kept for reference, the nurse reported she thought the care plans were kept in the resident's medical record (paper chart), but admitted she was not sure. An interview was conducted on 6/14/17 at 3:47 PM with Nurse #3. Nurse #3 typically worked on the 1st nursing shift. Upon inquiry as to where residents' care plans were kept for reference, the nurse stated they were kept in a binder on the	F 514	F514 Medical Records Accessible 1)On 7/6/17, Licensed Nurse moved resident care plans to corresponding nursing station units to ensure easy accessibility to records for direct care staff use. On 6/15/17, the licensed nurse completed an updated smoking assessment for resident #82 and filed in residents' medical record. Status of how resident is are able to smoke placed on Kardex 2)On 7/6/17, Director of Clinical Services monitored residents who smoke to ensure an updated smoking evaluation was available in residents' medical record. Kardexes updated to reflect residents' 3)On 6/29/17, Director of Clinical Services Re-educated direct care staff on maintaining accessible medical records for residents. Care plans to be kept in binders labeled by room number at the nursing station corresponding to resident room location. Resident evaluations, including smoking evaluations to be stored in the residents' individual medical record at the nurses' station. Smoking evaluations are completed by the licensed	

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F 514	Continued From page 42 Nursing Station. At the time of the interview, the nurse was unable to locate this binder and stated he was not sure where the care plans were. An interview was conducted on 6/14/17 at 3:48 PM with Nurse #6. Upon inquiry as to where residents' care plans were kept for reference, the nurse stated they were kept in the resident's paper chart. At that time, the nurse pulled a resident ' s paper chart and pointed out the resident ' s interim care plan (implemented upon initial admission to the facility only). The current care plan was not in the resident ' s paper chart. Nurse #6 also reported there was a Kardex binder (with care guides for the nursing assistants) kept at the nursing station for reference. An interview was conducted on 6/14/17 at 3:55 PM with MDS Nurse #2. During the interview, the nurse reported residents' care plans were stored in the MDS office during business hours. When asked where the residents' care plans were kept when an MDS nurse was not working, MDS Nurse #2 reported they stayed in the MDS office. Upon inquiry as to how staff accessed these, the nurse reported the MDS office was kept unlocked at all times to provide access to the residents ' care plans as needed. An interview was conducted on 6/15/17 at 6:45 AM with Nurse #7. When asked where the residents ' care plans were stored, Nurse #7 reported the residents ' care plans were kept in the paper charts. An interview was conducted on 6/15/17 at 11:20 AM with the facility ' s Administrator and Director of Nursing (DON). During the interview, it was	F 514	nurse upon admission, readmission, and quarterly and with significant change in condition and to be maintained in the residents' medical record for easy accessibility for direct care staff use. Newly hired direct care staff to be educated upon hire. 4)Minimum Data Set Nurses to complete quality improvement monitoring of 5 random residents to ensure care plan accessibility and storage at the nurses' station and storage of updated smoking evaluations in the medical record. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	

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revealed that only 1 of 5 nurses interviewed knew where residents ' care plans were kept so they could access them if needed. Upon inquiry, the Administrator reported the residents ' care plans needed to be accessible to direct care staff at all times. When asked if the care plans were readily accessible to staff while stored in the MDS office, the Administrator indicated they would likely be more accessible if kept on the nursing care units.

Based on resident and staff interviews, observations and record review, the facility failed to document a smoking evaluation for 1 of 3 residents reviewed for smoking safety, Resident #82.

Findings included:

The facility's smoking policy and procedure dated 11/30/14 (revised 01/20/17) revealed the residents who smoke would be evaluated on admission/re-admission, quarterly and with a change of resident's condition. Residents that were deemed unsafe to smoke independently would be supervised by staff during the smoking task.

Resident #82 was admitted to the facility on 07/05/16 and was readmitted to the facility from an acute hospital stay on 09/08/16. Resident #82 was admitted with diagnoses which included: chronic back pain, hypertension, anxiety, depression, dementia, acute renal insufficiency and deep vein thrombosis.

The care plan for resident #82, dated 05/25/17, revealed resident was a smoker and was to be assessed upon admission and quarterly. The care plan revealed staff were to instruct resident

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F 514	Continued From page 44 on smoking protocols, that smoking materials were to be kept locked at the nurse's station, designated smoking areas were to be used when smoking, smoking safety of resident was to be monitored and staff were to supervise resident when smoking. Resident #82's Quarterly MDS assessment dated 04/14/17, revealed resident experienced disorganized thinking at times and was noted to have moderately impaired cognition. Record review conducted revealed a Safe Smoking Assessment for Resident #82 was not present. The Director of Nursing (DON) was interviewed on 06/15/17 at 11:03 AM and asked if a Safe Smoking Evaluation had been performed for resident. The DON stated there should have been an evaluation done, but stated she was unable to locate the smoking assessment documentation. On 06/15/17 at 6:19 PM, an interview was conducted with the facility's Administrator, with the facility's DON in attendance. The Administrator stated she expected the smoking assessments to be completed when a resident was admitted to the facility and quarterly.	F 514		
F 516 SS=C	483.20(f)(5)(i)(ii); 483.70(i)(3) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 516		7/13/17

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F 516	Continued From page 45 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain residents' care plans in a secured location for 6 of 6 residence halls (100 Hall, 200 Hall, 300 Hall, 400 Hall, 500 Hall, and 600 Hall). The findings included: An interview was conducted on 6/14/17 at 3:40 PM with Nurse #1. Upon inquiry as to where residents' care plans were kept for reference, the nurse stated they were kept in the MDS office (referring to an office where nurses worked on residents ' Minimum Data Set or MDS assessments). The MDS office was located at the end (opposite from the nursing station) of one of the residents ' hallways. An interview was conducted on 6/14/17 at 3:55 PM with MDS Nurse #2. During the interview, the nurse reported residents' care plans were stored in the MDS office during business hours. When asked where the residents' care plans were kept when an MDS nurse was not working, MDS Nurse #2 reported they stayed in the MDS office. Upon inquiry as to how staff accessed these, the nurse reported the MDS office was kept unlocked at all times to provide access to the residents '	F 516	F516 Safeguarding Medical Records 1)On 7/6/17, Licensed Nurse moved resident care plans to corresponding nursing stations to ensure the safeguarding of residents' medical record against loss, destruction or unauthorized use. 2)Executive Director completed rounds of nursing stations and medical record storage area to ensure medical records are safeguarded against loss, destruction or unauthorized use. Follow up based on findings. 3)On 6/29/17, Director of Clinical Services Re-educated direct care staff on the safeguarding of residents' medical record against loss, destruction or unauthorized use. Care plans to be kept in binders labeled alphabetically at the nursing station corresponding to resident room location. Newly hired direct care staff to be educated upon hire. 4)Medical Records to complete quality improvement monitoring of 5 random	

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F 516	Continued From page 46 care plans as needed. An observation made on 6/14/17 at 7:00 PM revealed the MDS office door was wide open. A light was turned on in the room. No one was in the MDS office or within view of the office door at the time of the observation. An observation made on 6/15/17 at 6:40 AM revealed the MDS office door was closed and the light was off in the room. No one was in the MDS office or within view of the office door at the time of the observation. The door was unlocked. The residents ' care plans were observed to be stored in the office. An interview was conducted on 6/15/17 at 11:20 AM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the Administrator and DON were asked if there was any concern about storing protected patient information (specifically care plans) in an unattended, unlocked room. At that time, the Administrator acknowledged resident care plans contained protected patient information and would be expected to be kept in a secured location.	F 516	residents to ensure care plan safeguarding against loss, destruction or unauthorized use. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. AOC date- 7/13/17	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		7/13/17

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F 520	Continued From page 47 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and Q) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 05/19/2016, in order to achieve and	F 520	F520 QAPI 1)(F242)On 6/15/17, the licensed nurse completed an updated smoking evaluation and safety care plan for resident #21 and #119 to reflect their right to safely smoke	

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F 520	Continued From page 48 sustain compliance. The facility had a repeat deficiency for allowing resident choices (F 242). The facility had a repeat deficiency to prevent accidents and hazards (F 323), The facility had a repeat deficiency to implement a successful infection control program (F 441). The continued failure of the facility during two recertification surveys shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: 1.This F tag is cross referenced to F 242. 1.a. On 05/19/2016, the facility failed to allow one of one resident a choice in bath type and frequency. 1.b. On 06/15/2017, the facility failed to honor preferences related to smoking for two of two residents reviewed and were assessed to be safe smokers. An interview conducted on 06/15/2017 at 3:03 PM with the facility's Administrator revealed that she was the contact person for the Quality Assessment and Assurance Committee and that the facility had no action plan in place to monitor that the facility would followed the regulations for safe smoking and resident choices for safe smoking. 2. This F tag is cross referenced to F 323. 2.a. On 05/19/2016, the facility failed to supervise one of three residents evaluated as unsafe smokers. 2.b. On 06/15/2017, the facility failed to maintain three of three resident shower rooms in a	F 520	independently at times of their choice. (F323)On 6/15/17, the Maintenance Director replaced the thermostat in the 200 hall shower room. Shower rooms continue to be free from accident hazards by ensuring doors are locked with key pad access, storing chemicals and bath products with lids in locked cabinets and performing routine maintenance. (F441)Resident #6 and #126 are no longer on enteric isolation precautions for Clostridium Difficile and did not experience harm from improper handwashing. On 6/14/17, the Director of Clinical Services provided 1:1 reeducation to nurse aide #1, 2 and 3 and nurse #1 on following the enteric isolation precautions of washing hands with warm soap and water before leaving residents' room to prevent the spread of communicable infections. 2) (F242)On 7/6/17, Director of Clinical Services Re-evaluated residents' ability to safely smoke and updated their safety care plans accordingly. Safe smokers have been reeducated on their right to smoke independently at times of their choice. Smoking materials are to be maintained by facility staff for safety of all residents. (F323)O 6/15/17, the Maintenance Director and Executive Director inspected facility shower rooms to ensure a safe environment free from accident hazards for residents. (F441)On 6/14/17, licensed nurses assessed residents for signs and symptoms of Clostridium Difficile and no	

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F 520	Continued From page 49 secured manner to prevent resident accidents and hazardous condition. An interview conducted on 06/15/2017 at 3:03 PM with the facility's Administrator revealed that she was the contact person for the Quality Assessment and Assurance Committee and that the facility had no action plan in place to monitor that the facility maintained the shower rooms to be free of accident hazards to residents. 4. This F tag is cross referenced to F 441. 4.a. On 05/19/2016, the facility failed to post a contact isolation sign for a resident that was positive for MRSA (Methicillin Resistant Staph Aureus) for one of four residents reviewed. 4.b. On 06/15/2017, the facility failed to implement and follow handwashing protocol after providing care of residents under special enteric contact isolation precautions for two of three residents reviewed. An interview conducted on 06/15/2017 at 3:03 PM with the facility's Administrator revealed that she was the contact person for the Quality Assessment and Assurance Committee and that the facility had an action plan in place to implement the infection control program and that staff education was also included in the current action plan.	F 520	additional residents were identified. 3)(F242)On 6/29/17, Director of Clinical Services Re-educated facility staff on residents rights to self choice and the facilities updated smoking policy. A "Resident Smokers" list is posted at the nurses' station to alert staff of safe/unsafe smokers and staff-assisted smoking times for unsafe smokers. Unsafe smokers have posters in their rooms that display the facilities supervised smoking times. A designated smoking area is clearly identified and safety equipment available. On 6/29/17, the DCS re-educated licensed nurses on the accurate completion of the smoking evaluation on the Admission and Quarterly Data Collection and the Safe Smoking Evaluation upon admission, readmission, quarterly, or with changes in smoking status or ability to safely smoke. Newly hired nursing staff will be educated upon hire. (F323)On 6/15/17, the Executive Director reeducated the Maintenance Director on performing routine maintenance inspections and repairs of the shower rooms to maintain a safe environment, free from accident hazards. On DATE???, the Director of Clinical Services reeducated nursing staff on maintaining a safe environment, free from accident hazards by storing bath products and chemicals with lids in locked cabinets, keeping shower room doors locked with key pad and reporting to maintenance any areas needing repair and/or replacement	

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F 520	Continued From page 50	F 520	immediately. Newly hired maintenance and nursing staff will be educated upon hire. The Maintenance Director and/or designee to inspect shower rooms daily and upon request to ensure safe, well maintained conditions, free from accident hazards. Nursing staff to maintain a safe environment, free from accident hazards in shower rooms by storing bath products and chemicals with lids in locked cabinets, keeping shower room doors locked with key pad and reporting to maintenance any areas needing repair and/or replacement immediately. (F441) 6/14/17 & 6/29/17, the Director of Clinical Services and Executive Director re-educated facility staff on preventing the spread of infections by proper handwashing. Education for enteric isolation precautions included washing of hands with warm soap and water prior to leaving residents' room. Newly hired staffs to be educated upon hire. Residents with orders for enteric isolation to have visual signage on the outside of their room door, along with appropriate PPE equipment available to staff to prevent the spread of communicable infections. Staff to wash hands with warm soap and water before leaving residents rooms when caring for residents on enteric isolation. Visitors to receive education regarding infection control practices for residents on enteric isolations precautions. On 7/10/17, the Regional Director of Clinical Services re-educated the Interdisciplinary Team (IDT), including the	

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F 520	Continued From page 51	F 520	Executive Director, Maintenance Director, Admissions Director and Coordinator, Medical Records, Social Services, Business Officer Manager, Director of Clinical Services, Minimum Data Set Director, Dietary Manager and Central Supply on Federal Regulation F520 and Consulates QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI)program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been identified to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. 4)(F242) Social Service Designee To complete quality improvement monitoring of resident smokers to ensure safe smokers right to smoke independently at times of their choice is being honored. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee	

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F 520	Continued From page 52	F 520	to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. (F323)The Executive Director to complete quality improvement monitoring of facility shower rooms to ensure a safe environment, free from accident hazards is maintained. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. (F441) Director of Clinical Services or designee To complete quality improvement monitoring of residents on enteric isolation for appropriate handwashing practice. Monitoring to be completed at a frequency of 2x/week for 4 weeks, 1x/week for 8 weeks then, monthly for 9 months and results reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action or monitoring frequency as necessary. The Regional Director of Clinical Services and/or the Regional Vice President of	

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F 520	Continued From page 53	F 520	Operations to attend the facility QAPI meeting at a minimum of quarterly to evaluate the effectiveness of the program and compliance with the ongoing monitoring and revision to the plan of correction for F242, F323 and F441 as appropriate to maintain compliance. Reeducation, use of outside resources and/or disciplinary action to be implemented as necessary to reduce the risk of repeat citations.	