STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 10/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US HIGHWAY 70 SWANNANOA, NC 28778**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 11/28/17 because the State Agency made revisions to the language in tags F-170 and F-241. Event ID# OBSR11.	F 000		
F 170 SS=E	RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL CFR(s): 483.10(g)(8)(i)(9)(i)-(iii)(h)(2) (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a	F 170		11/21/17

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

Electronically Signed | 12/01/2017

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F 170	Continued From page 1 postal service. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review the facility failed to deliver mail to the residents on Saturdays. Findings include: Review of resident rights revealed residents have the right to privacy to send and receive unopened mail including on Saturdays. An interview on 10/26/2017 at 10:30 AM with Resident #4 revealed she delivered the mail to residents at the facility. The resident stated, on Saturdays she was not provided mail to deliver to residents. Resident #4 further stated, when she delivers the mail the front desk person gives mail to the office, they sort it and then give it to her to deliver. The resident specified, the facility will wait until Monday to deliver the mail that the residents receive on Saturday's. An interview on 10/26/2017 at 11:21 AM with the Receptionist #1 at the front desk revealed she use to work Saturdays but they did away with a Saturday receptionist and now she worked two days during the week. She stated the mail is delivered to the mailbox out front across from the main door daily. She stated she and Resident #4 who had been approved to distribute the mail delivered it to the residents. She stated she guessed that it just stayed in the mail box until Monday now that there was no one working as a receptionist on Saturdays. An observation on 10/26/2017 at 11:23 AM of the facility's mailbox revealed it was across the	F 170	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is submitted solely because it is required by the provision of federal and state law. F-170 483.10V(g)(8)(i)(9)(i) □ (iii)(h)(2) RIGHT TO PRIVACY □ SEND/RECEIVE UNOPENED MAIL 11.21.17 1. The plan of correcting the deficiency and the process that lead to the deficiency: The facility failed to have a process that included a designated person to distribute the mail on Saturdays . To correct this, on 10/26/17, Administrator added checking and delivery of mail to weekend manager duty job functions to ensure mail is checked and delivered to residents timely on the weekends. 2. The process for implementing the plan of correction includes: On 10/26/17, Administrator provided in-service education to all department heads on checking and delivering mail as part of weekend manager on duty job functions. 3. The monitoring procedure to ensure that the	

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F 170	Continued From page 2 driveway in front of the main entrance to the building. It had outgoing mail in it with the flag up waiting for the mail person to pick it up and deliver the day's mail to the facility. A phone interview on 10/26/2017 at 11:41 AM with the local Interim Post Master #1 revealed they had a list of businesses that are closed on the weekend and they don't deliver mail to these businesses. He stated the facility was not on this list so mail was delivered on Saturdays to the facility. An interview on 10/26/2017 at 4:28 PM with Activity Staff #1 revealed she was part time and had worked two Sundays. She stated she had distributed newspapers and looked on the main desk but there was no mail for her to deliver to residents on those two days. She stated she had not worked any Saturdays since she returned to work at the facility so I did did not deliver or know about mail any mail on Saturdays. An interview on 11/26/2017 at 6:50 PM with the Administrator revealed her expectation was that mail would be delivered to all residents who received mail on the weekend.	F 170	plan of correction is effective and that the specific deficiency remains corrected and/or in compliance with regulatory requirements: Beginning 11/21/17, Administrator will interview a random sample consisting of 10% of alert and oriented residents to ensure mail was delivered over the weekend. Audits will occur weekly x four weeks and monthly x three months. Any noncompliant areas discovered during audits will be addressed with the respective department head at that time. Effective Nov. 21st, 2017, findings for mail delivery audits will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. 4. The title of the person responsible for implementing an acceptable plan of correction is the Administrator. The Administrator will be responsible to ensure implementation of this plan of correction and ensure that the plan is followed with verification by the Regional Nurse Consultant and Regional Director of Operations during facility visits	

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F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to treat 1 of 1 resident (Resident #53) in a dignified manner by sending him to his room when he requested assistance with getting a shower on the evening shift. The findings included: Resident #53 was admitted to the facility on 10/01/17 for rehabilitation following a hospitalization. His diagnoses included hypertension, diabetes mellitus, encephalopathy and depression. A review of Resident #53's admission Minimum Data Set (MDS) dated 10/08/17 revealed he had moderately impaired vision with no glasses, adequate hearing, was understood and understands, and cognitively intact. Resident #53 had trouble falling or staying asleep and feeling tired or having little energy 2-6 days and felt bad about himself and had trouble concentrating on things 12-14 days. He had no behaviors and required limited to extensive assistance of 1-2 persons with most activities of daily living (ADL) and was totally dependent on 1 person for bathing. Resident #53 utilized a wheelchair for mobility and was currently receiving physical	F 241	F-241 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY 11.21.17 1. The plan of correcting the deficiency and the process that lead to the deficiency: Two nurses failed to treat Resident #53 in a manner that he considered dignified. The nurses had been previously trained on the facility□s policies and procedures for treating all residents with dignity and respect while maintaining resident rights. To correct this the Administrator immediately initiated an investigation on 10/17/16. The two nurses were informed that they were being placed on administrative leave pending the outcome of the investigation. At the conclusion of the investigation the nurses were returned to duty and were provided one-on-one inservice education. 2. The process for implementing the plan of correction includes: On 10/17/17, the two nurses identified were provided 1:1 in-service education by the Administrator and Regional Director of Operations including the topics of abuse, customer service, and resident rights. All other staff were also provided in-service	11/21/17

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F 241	Continued From page 4 therapy and occupational therapy. He was occasionally incontinent of urine and always continent of stool. Resident #53 received insulin injections, antidepressants and diuretics for 7 days, antibiotic for 4 days and opioid for 6 days. He was on oxygen therapy and utilized continuous positive airway pressure (C-PAP) at night. A review of Resident #53's admission Care Area Assessment (CAA) summary dated 10/09/17 revealed he triggered for ADL. The ADL CAA summary revealed that he was admitted from a local hospital following an acute stay for new onset confusion and falls with possible oxycodone overdose. His acute encephalopathy resolved during his hospitalization and it was questionable if he was using his C-PAP at night while home. He did have some burning with urination and it was questionable if he had a urinary tract infection that caused the acute encephalopathy or if it was a result of overdose of pain medication. His other diagnoses included hypothyroidism, cor pulmonale, seizure disorder, debility, atrial fibrillation, coronary artery disease (CAD), lower extremity cellulitis, chronic pain, peripheral vascular disease (PVD) and pulmonary hypertension. He was admitted to the facility for rehabilitation and required assistance with bed mobility, transfers, toileting, bathing and dressing. He had occasional bladder incontinence but was continent of his bowel function. He wore adult briefs for the protection of his skin and clothing and received antidepressants, diuretics and opioids during this review. A review of Resident #53's care plan dated 10/01/17 revealed he was care planned for ADL self-care performance deficit related to his acute	F 241	education by Director of Nursing and Regional Nurse Consultant between 10/17/19 and 10/20/17 on abuse, customer service, and resident rights. Department heads conducted 100% audit of residents cared for by the 2 nurses on 10/17/16 to see if any dignity issues or resident rights violations were noted. No further issues identified. On 10/17/17, all resident with a BIMS score above 7 (per the most recent MDS assessment) were interviewed by department heads related to feelings of safety and any concerns they had regarding safety. Those residents with BIMS scores of 7 or less were evaluated by the licensed nurse or C.N.A. assigned to that resident for any signs of fear and/or changes in behavior. No additional concerns were noted. 3. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency remains corrected and/or in compliance with regulatory requirements includes: Beginning 11/21/17, Administrator or designee will interview a random sample of 10% of interviewable residents weekly x four weeks and then monthly x 3 months to ensure there are no concerns with dignity, respect, or resident rights violations. Any noncompliant areas discovered during interviews will be addressed with the frontline staff at that time. Effective Nov. 21st, 2017, audit findings	

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F 241	Continued From page 5 encephalopathy, atrial fibrillation, seizure disorder, debilitation, peripheral vascular disease with weeping edema on both lower extremities. The goal was for the resident to show improvement in his ability to perform care and return to his prior level of function with a target date of 01/07/18. The interventions included to provide am care as preferred by the resident including dressing/grooming with assistance of 1 person for ADL. Encourage resident to participate to fullest extent possible and praise all efforts. Use task segmentation as needed. Assist resident with bathing, grooming, toileting, bed mobility and dressing as needed. During an interview with Resident #53 on 10/24/17 at 3:07 pm he stated that he was not treated with dignity and respect. He stated that there were some staff that were real good and others that should not have their license. He stated that he had an incident with 2 nurses on the evening shift on 10/16/17. He stated Nurse #1 and #2 said in part "go to your room and don't come out the rest of the night." Resident #53 stated he had gone out to the nurse's desk to request assistance with his shower. He stated he knocked on the side of the medication cart to get someone's attention and when he requested assistance with his shower they told him to go to his room and told him they were assisting with dinner and there was no one to help him until after dinner. He stated the nurses were very disrespectful and made him feel degraded talking to him in that manner. An interview with Nurse #1 on 10/26/17 at 2:50 pm revealed she remembered the incident with Resident #53. She stated he came out to the nurse's station around 5:00 pm on 10/16/17 and	F 241	for dignity, respect, and resident rights will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. 4. The title of the person responsible for implementing an acceptable plan of correction is the Administrator. The Administrator will be responsible to ensure implementation of this Plan of Correction and ensure that the plan is followed with verification by the Regional Nurse Consultant and Regional Director of Operations during visits.	

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F 241	Continued From page 6	F 241		

was belligerent and pounded on the side of the medication cart and demanded to have his shower. Nurse #1 stated she told him the nursing assistants (NA) were passing trays and helping with feeding residents and he needed to go back to his room and eat his dinner and they would assist him with his shower after dinner was done. She stated he rolled back to his room and he got his shower after dinner was done.

An interview with Nurse #2 on 10/26/17 at 2:53 pm revealed she remembered the incident with Resident #53. She stated he came out to the nurse's desk and started yelling that he wanted his shower right now and we told him trays were being passed and there was only one NA on the hall. Nurse #2 stated she suggested he go to his room and eat dinner and they would help him get a shower as soon as dinner was finished. She stated he rolled back to his room and the NA assisted him with his shower after dinner.

An interview with NA #1 on 10/26/17 at 4:33 pm revealed that she remembered the incident between Resident #53 and Nurse #1 and #2. She stated she was at the desk and the resident came up and asked for assistance in getting his shower. NA #1 stated Nurse #1 and #2 said to the resident "go to your room and I don't want to see you the rest of the night." NA #1 stated she could not remember exactly what time it happened but it was around dinner time and both nurses said something to the resident about going to his room. NA #1 stated the resident was not belligerent and was not yelling. She stated the resident has a deep voice but he was not yelling. NA #1 stated as soon as she finished with dinner, she assisted Resident #53 with getting his shower.

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F 241	Continued From page 7 An interview with the Director of Nursing (DON) on 10/27/17 at 2:27 pm revealed that she was aware of the incident with Resident #53 and Nurse #1 and #2. She stated the resident had come to the office looking for the administrator and one of the regional consultants was there and the resident told him about the incident and how it made him feel degraded the way the nurses talked to him. The DON stated it was her expectation that residents be treated with dignity and respect at all times by all staff. An interview with the Administrator on 10/27/17 at 3:39 pm revealed it was her expectation that all residents be treated with dignity and respect at all times, "even if they are being tested" by the residents.	F 241		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (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 interviews the facility failed to repair 7 of 7 sets of smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (southeast 300 hall, northeast 300 hall, entrance to the west unit, southwest 200 hall, northwest 200 hall, 100 hall near the main dining room and 100 hall at the lobby). The facility also failed to repair 2 main dining room doors with broken and splintered laminate and wood on the lower edges of the doors and failed to repair 2 resident room doors with broken and splintered	F 253	F-253 483.10 (i)(2) HOUSEKEEPING AND MAINTENANCE SERVICES 1. The plan of correcting the deficiency and process that lead to the deficiency: The facility failed to have a procedure to ensure splintered doors were repaired timely. 2. To correct this, the maintenance director began sanding the broken and splintered	11/21/17

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F 253	Continued From page 8 laminate and wood (#311 and #222) for 2 of 55 resident rooms on 2 of 3 resident hallways (200 and 300 halls). Findings included: 1. a. Observations on 10/25/17 at 2:20 PM revealed 2 smoke prevention doors on the southeast 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/26/17 at 11:15 AM revealed 2 smoke prevention doors on the southeast 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/27/17 at 1:36 PM revealed 2 smoke prevention doors on the southeast 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. b. Observations on 10/25/17 at 2:22 PM revealed 2 smoke prevention doors on the northeast 300 hall with broken and splintered laminate and wood on the right door that was rough to touch. Observations on 10/26/17 at 11:20 AM revealed 2 smoke prevention doors on the northeast 300 hall with broken and splintered laminate and wood on the right door that was rough to touch. Observations on 10/27/17 at 1:37 PM revealed 2 smoke prevention doors on the northeast 300 hall with broken and splintered laminate and wood on the right door that was rough to touch. c. Observations on 10/25/17 at 2:24 PM revealed 2 smoke prevention doors at the entrance of the west unit with broken and splintered laminate and wood on the lower edges of the doors that were	F 253	doors on 10/26/17 which included 7 sets of smoke prevention doors (southeast 300 hall, northeast 300 hall, entrance to west unit, southwest 200 hall, northwest 200 hall, 100 hall near the main dining room and 100 hall at the lobby), 2 main dining room doors, and 2 of 55 resident room doors (room #311 and #222) with a projected final completion date of 11/22/17. 3. The process for implementing the plan of correction includes: On 10/26/17 Administrator began in-service education with Maintenance Director on checking doors for broken or splintered laminate covering. Audits were completed for November on 11/22/17. Maintenance director will add an ongoing monthly check of all doors to the automated work order system effective 12/1/17. 4. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency remains corrected and/or in compliance with regulatory requirements includes: Beginning 12/1/17, Maintenance Director or housekeeping director will audit a random sample of 25% doors in the facility weekly x four weeks then monthly	

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F 253	Continued From page 9 rough to touch. Observations on 10/26/17 at 11:23 AM revealed 2 smoke prevention doors at the entrance of the west unit with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/27/17 at 1:40 PM revealed 2 smoke prevention doors at the entrance of the west unit with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. d. Observations on 10/25/17 at 2:25 PM revealed 2 smoke prevention on the southwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/26/17 at 11:25 AM revealed 2 smoke prevention doors on the southwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/27/17 at 1:42 PM revealed 2 smoke prevention doors on the southwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. e. Observations on 10/25/17 at 2:27 PM revealed 2 smoke prevention doors on the northwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/26/17 at 11:27 AM revealed 2 smoke prevention doors on the northwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 10/27/17 at 1:44 PM revealed 2	F 253	x three months. Any noncompliant areas discovered during inspections will be corrected at that time. Effective Nov. 21st, 2017, audit findings for door checks will be reported by the Maintenance Director to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. 4. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. The Administrator will be responsible to ensure implementation of this plan of correction and ensure that the plan is followed with verification of the Regional Nurse Consultant and Regional Director of Operations during visits.	

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smoke prevention doors on the northwest 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.

f. Observations on 10/25/17 at 2:29 PM revealed 2 smoke prevention on the 100 hall near the main dining room with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/26/17 at 11:29 AM revealed 2 smoke prevention doors on the 100 hall near the main dining room with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/27/17 at 1:45 PM revealed 2 smoke prevention doors on the 100 hall near the main dining room with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.

g. Observations on 10/25/17 at 2:30 PM revealed 2 smoke prevention on the 100 hall at the lobby with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/26/17 at 11:31 AM revealed 2 smoke prevention doors on the 100 hall at the lobby with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/27/17 at 1:46 PM revealed 2 smoke prevention doors on the 100 hall at the lobby with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.

2. Observations on 10/25/17 at 2:32 PM revealed 2 doors at the main dining room with broken and

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splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/26/17 at 11:32 AM revealed 2 doors at the main dining room with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.
Observations on 10/27/17 at 1:47 PM revealed 2 doors at the main dining room with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.

3. a. Observations on 10/25/17 at 2:35 PM of resident room #311 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.
Observations on 10/26/17 at 11:36 AM of resident room #311 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.
Observations on 10/27/17 at 2:21 PM of resident room #311 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.

b. Observations on 10/25/17 at 2:38 PM of resident room #222 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.
Observations on 10/26/17 at 11:38 AM of resident room #222 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.
Observations on 10/27/17 at 2:23 PM of resident room #222 revealed broken laminate and wood with visible splinters on the lower edges of the door that was rough to touch.

During an interview and environmental tour on 10/27/17 at 2:11 PM, the Maintenance Director

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F 253	Continued From page 12 stated the facility utilized a work order system. He explained he used a computerized system and a paper work order system and there were work orders at the nurse's stations where staff could fill out concerns and repairs that needed to be made. He stated he reviewed work orders on a daily basis and when staff filled out a paper work order he entered it into the computer system so it could be tracked. He confirmed he was the only maintenance staff in the facility and sometimes staff stopped him when he made his rounds to tell him about repairs that needed to be made but he entered the information into the computerized work order system so he would not forget it. He explained he reviewed the work order system with new employees in orientation so they would know to fill out work orders for repairs. He stated he did a monthly room check and if he found anything that could cause a skin tear or a scratch he repaired that right away and any doors with rough edges or splinters should be a high priority because they could cause skin tears. During the environmental tour he confirmed the smoke prevention doors and dining room doors needed to be sanded and resident doors with splinters needed to be taken care of right away to sand and smooth them. During an interview on 10/27/17 at 2:41 PM the Administrator stated a new company had taken over the facility a few weeks ago and she would expect for doors with splintered and rough edges to be sanded and fixed. She stated they had done a walk-through of the facility and identified areas of concerns but they had not developed a plan and it was a work in progress.	F 253		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		11/21/17

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F 323	Continued From page 13 CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (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. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure safe smoking practices were followed when a resident kept a lighter and cigarettes at the bedside for 1 of 2 residents who smoked (Resident #36). The facility also failed to store hazardous chemicals out of reach of residents when a deodorizing spray was left in a resident's room for 1 of 3 resident's sampled for supervision to prevent accidents (Resident #53).	F 323	F 323 □ 483.25 (d)(1)(2)(n)(1)-(3) FREE OF 11.21.17 ACCIDENT HAZARDS/SUPERVISION/ DEVICES 1. The plan of correcting the deficiency and the process that led to the deficiency. The facility failed to have a procedure for securing lighters and the facility failed to follow the policy for securing chemicals. To correct this on 10/26/17 Administrator	

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F 323	Continued From page 14 Findings included: 1. Resident #36 was re-admitted to the facility on 05/18/09 with diagnoses which included epilepsy, high blood pressure, chronic pain, high cholesterol, dementia, anxiety and generalized mood disorder. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/15/17 indicated Resident #36 was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #36 required supervision with activities of daily living and had no impairment of upper or lower extremities on either side. A review of a care plan dated September 2017 revealed Resident #36 was a smoker and the goal was Resident #36 would not suffer injury from unsafe smoking practices. The interventions indicated to instruct Resident #36 about smoking risks and hazards and about smoking cessation aids that were available, instruct Resident #36 about the facility policy on smoking locations, times, safety concerns, notify charge nurse immediately if it was suspected Resident #36 had violated facility smoking policy, observe clothing and skin for signs of cigarette burns and Resident #36 could smoke unsupervised. A review of a facility document titled Smoking - Safety Screen dated 09/01/17 indicated Resident #36 had cognitive loss and visual deficits and smoked 2-5 cigarettes a day and preferred to smoke in the afternoon and evenings. The document revealed Resident #36 could light her own cigarette, needed the facility to store lighter and cigarettes and the plan of care was used to	F 323	removed cigarettes and lighter from the room of Resident #36 with Resident #36□s permission, and placed them in the medication cart on Resident #36□s hallway. On 10/24/17 Corporate nurse removed the air freshener spray from Resident #53s room. 2. The process for implementing the plan of corrections includes: On 10/26/17 Administrator did a sweep of the rooms of all other known smokers. No additional cigarettes and lighters were found. On 10/24/17 housekeeping director inspected resident rooms to ensure there was no access to chemicals and room deodorizers. No additional chemicals or room deodorizers were found. Starting 11/21/17, staff were provided inservice education by the Administrator regarding items that residents should not have access to unsupervised, including but not limited to, cigarettes, lighters and deodorizing chemicals. 3. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency remains corrected and/or in compliance with regulatory requirements: Beginning 11/22/17, Administrator or	

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F 323	Continued From page 15 assure Resident #36 was safe while smoking. The document also revealed the team decision was Resident #36 was safe to smoke without supervision. During an interview on 10/25/17 at 4:38 PM the Administrator stated technically the facility was smoke free but verified they had 2 residents who smoked and they were expected to go off the facility property to a designated smoking area when they wanted to smoke. During an observation on 10/26/17 at 8:03 AM there were 3 small signs in front of the facility which indicated in part tobacco and smoke free campus. During an interview and observation on 10/26/17 at 9:59 AM with Resident #36 she stated she had just gotten back to her room from going outside to smoke. She explained she went out the front door to the main parking lot and went up the steps to the next street to smoke and there was a bucket with sand and rocks in it to put out her cigarette. She stated she kept her cigarettes and lighter at the bedside so she could go outside to smoke anytime she wanted and then she pulled open the top drawer of her bedside table and pointed to a lighter and 1 pack of cigarettes and stated that was where she kept them all the time. During an observation on 10/26/17 at 3:20 PM Resident #36 was sitting on the top step above the main parking lot next to the street and was smoking a cigarette. She stood and dropped the cigarette butt into a bucket labeled cigarette butts and walked down the steps and through the parking lot and entered the front door of the facility. She then walked down the hall past a	F 323	designee will audit identified smokers rooms and the in/out log for smoking paraphanalia weekly x four weeks then monthly x three months to ensure no lighters or cigarettes are present in patient rooms. Beginning 11/20/17, Housekeeping Director will audit a 10% random sample of rooms for the presence of deodorizing chemicals weekly x four weeks and monthly x three months. Any noncompliant areas discovered during audits will be addressed with the frontline staff at that time. On 11/21/17 a sign in/out log for smoking paraphanalia was implemented for each of the smokers in the center. Smokers and nurses were educated to log smoking paraphanalia in/out per each use. Effective Nov. 21st, 2017, audit findings for storage of cigarettes, lighters, and deodorizing chemicals will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping	

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F 323	Continued From page 16 medication cart and a nurse who was standing at the cart and walked to her room, opened the top drawer of a bedside table next to her bed and placed a pack of cigarettes and a lighter inside the drawer. During an interview on 10/26/17 at 3:44 PM, Nurse #8 confirmed there were a couple of residents in the facility who smoked. She explained the residents were supposed to stop and tell the nurse when they went out to smoke and they were also supposed to turn in their lighter and cigarettes when they came back inside from smoking but they didn't always do that. During an interview on 10/26/17 at 3:50 PM, Nurse #9 who was also the West Unit Coordinator explained the facility was a non-smoking facility but residents who were alert and oriented and ambulatory who chose to smoke had to go off the facility property which was up the steps next to the facility parking lot to an upper parking lot at an adjacent street. She stated residents were not allowed to have an ignition source in their room at any time which included lighters. She explained residents were supposed to let a staff member know when they went out to smoke and they were supposed to turn in cigarettes and lighters to the nurse when they came back into the facility. She further explained lighters and cigarettes were supposed to be kept in the medication cart or they could be stored on a shelf in her office. She stated Resident #36 was alert and oriented and was assessed as a safe smoker but was not supposed to keep her lighter and cigarettes in her room.	F 323	Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. 4. The title of the person responsible for implementing the acceptable plan of correction is the Administrator. The Administrator will be responsible to ensure implementation of this Plan of Correction and ensure that the plan is followed with verification by the Regional Nurse Consultant and Regional Director of Operation during facility visits.	

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During an observation on 10/26/17 at 4:03 PM Resident #36 walked down the hall toward her room and Nurse #9 asked her where she had been. Resident #36 stated she had been outside to smoke and when Nurse #9 asked if she had given her lighter and cigarettes to the nurse she stated "no, and I'm not going to." Resident #36 further stated she would not give them to the nurses because she could not get them whenever she wanted to go out to smoke. Resident #36 then walked into her room and placed her cigarettes and lighter inside her closet.

During an interview on 10/26/17 at 4:05 PM, Nurse #9 confirmed she observed Resident #36 putting her cigarettes and lighter into her closet. She stated no resident could have a lighter which was an ignition source in their room and she was not aware Resident #36 had kept a lighter or cigarettes in her room. She then called the Administrator to talk with Resident #36.

During an interview on 10/26/17 at 4:10 PM, the Administrator stated Resident #36 was not supposed to have a lighter in her room.

During an interview on 10/27/17 at 2:46 PM, the Director of Nursing stated it was her expectation that residents who smoked at the facility had to turn their lighters in to a nurse when they came back inside the facility from smoking. She explained if the resident could not find the nurse assigned to them, they should give it to any nurse.

During a follow up interview on 10/27/17 at 3:38 PM, the Administrator stated it was her expectation residents should follow safety precautions and should turn in their smoking

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paraphernalia when they came back inside the facility from smoking. She further stated residents should not keep cigarettes or lighters in their rooms.

2. Resident #53 was admitted to the facility on 10/01/17 for rehabilitation following a hospitalization. His diagnoses included hypertension, diabetes mellitus, encephalopathy and depression.

A review of Resident #53s admission Minimum Data Set (MDS) dated 10/08/17 revealed he had moderately impaired vision with no glasses, adequate hearing, was understood and understands, and cognitively intact. He had no behaviors and required limited to extensive assistance of 1-2 persons with most activities of daily living (ADL). Resident #53 utilized a wheelchair for mobility. Resident #53 was on oxygen therapy and utilized continuous positive airway pressure (C-PAP) at night.

A review of Resident #53s admission Care Area Assessment (CAA) summary dated 10/09/17 that he was admitted from Mission Hospital following an acute stay for new onset confusion and falls with possible oxycodone overdose. His acute encephalopathy resolved during his hospitalization and it was questionable if he was using his C-PAP at night while home. He did have some burning with urination and it was questionable if he had a urinary tract infection that caused the acute encephalopathy or if it was a result of overdose of pain medication. His other diagnoses included hypothyroidism, cor pulmonale, seizure disorder, debility, atrial fibrillation, coronary artery disease (CAD), lower extremity cellulitis, chronic pain, peripheral

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vascular disease (PVD) and pulmonary hypertension. He was admitted to the facility for rehabilitation and required assistance with bed mobility, transfers, toileting, bathing and dressing. He had occasional bladder incontinence but was continent of his bowel function. He wore adult briefs for the protection of his skin and clothing and received antidepressants, diuretics and opioids during this review.

An observation and initial interview with Resident #53 on 10/24/17 at 3:07 pm revealed that he had a room deodorizing spray can on his bedside table. The resident stated the can was in his room when he was admitted and he used it because there were smells from out in the hall that he did not want in his bedroom.

A review of a "Behavioral note" in Resident #53s chart written 10/26/17 at 8:38 am read in part. "Signee approached east nurses station and charge nurse was informing resident he couldn't keep spray air freshener in room, resident stated he wanted it back now, charge nurse asked signee if he could have it and signee stated no, but would check into it further. Resident sitting in wheelchair (w/c) directly beside signee, draws hands into fist, shakes fist at signee and states give me my air freshener back. Signee again explains he was unable to keep in his room, resident remained with hands drawn into fist and states he wants it and if he can't have it why is it here. Signee assured resident and staffs safety and left unit. Resident will be monitored for continued behaviors." The note was signed by the corporate nurse.

During an interview with Resident #53 on 10/26/17 at 10:41 am he stated that he had a can

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of deodorizing spray in his room that was there when he was admitted to the room and someone came in and took it from him and did not tell him why they took it and had not brought it back. The resident stated he used the spray because there were smells from the hallway that he did not want to smell in his bedroom. He stated when the girl came in and took it and he asked why she was taking it she just brushed him off.

An interview with Nurse #6 on 10/26/17 at 2:19 pm revealed the resident was in the hall when she came in and said that some girl came into his room and took his air freshener spray and did not tell him why. She stated that residents were not allowed to have spray in their rooms and she had been told only housekeeping could have sprays.

An interview with Nurse #7 on 10/26/17 at 2:25 pm revealed that it was the corporate nurse who had Resident #53s spray. She stated the nurse on night shift had taken his air freshener and the corporate nurse had not given it back to him yet because she needed to be sure it was safe for him.

An interview with the corporate nurse on 10/26/17 at 2:35 pm revealed that she had Resident #53s air freshener spray and had not given it back to him because she wanted to assure that it was safe for him to have it with his respiratory issues. She stated that she was not aware that Resident #53 had had the spray since he was admitted to the facility.

An interview with the Housekeeping Manager on 10/26/17 at 2:50 pm revealed that all air freshener sprays and all sprays containing chemicals should remain locked up in the

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F 323	Continued From page 21 housekeeping closet and should not be in the resident rooms. A review of the Housekeeping Policy and Procedure effective date 05/01/17 read in part under procedure: 8. Make daily rounds of supply closets checking for proper labeling of chemicals and proper storage. An interview with the Director of Nursing (DON) on 10/27/17 at 2:47 pm revealed that it was her expectation that chemicals that are not appropriate for residents should be locked up and if in a resident room, let the resident know they are taking it out of the room for safety reasons. An interview with the Administrator on 10/27/17 at 3:39 pm revealed that she expected chemicals to be safely stored and locked in the housekeeping closet.	F 323		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		11/22/17

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F 371	Continued From page 22 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to remove items in dry storage and the refrigerator that were past the use by date on the items, (5 bags of tortillas shells, 3 5-pound bags of coleslaw mix) and label items in the dry storage and freezer with the name of item, date opened and date to use by. (1 bag opened pasta, 2 bags frozen guacamole, 5 bags frozen French toast, 1 opened and 15 other bags of hash browns no label or date, 5 bags of frozen cauliflower no label or date). The facility failed to cook the dinner menu item per the manufacturer's cooking instructions to the recommended temperature. (1 pan of stuffed peppers). Findings included: 1. Review of the facility's food receiving and storage policy dated 2014 revealed dry foods labeled and dated ("use by" date). Foods will be rotated using first in-first out" system. All foods stored in the refrigerator or freezer will labeled covered, labeled and dated ("use by" date). An observation on 10/24/2017 at 10:00 AM in the dry storage area revealed:	F 371	F 371 □ 483.60 (I)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE □ SANITARY 11.22.17 1. The plan of correcting the deficiency and the process that led to the deficiency. The facility failed to follow policies to ensure that expired or undated foods are discarded timely. Cook #1 failed to ensure food was heated to manufacturer□s recommendations. To correct this on 10/24/17 Dietary manager discarded 5 expired packages of tortilla shells, and 1 large bag of expired couscous. On 10/25/17 Dietary manager discarded 5 packages of French toast, one opened bag of hash browns, 15 closed bags of hash browns, 5 bags of cauliflower, and 2 bags of guacamole. On 10/25/17 Cook #1 discarded one pan of stuffed peppers. 2. The process for implementing the plan of correction includes: On 10/25/17, the dietary manager	

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F 371	Continued From page 23 5 packages of multiple tortilla shells with an expired date of 10/23/2017 1 large 10 pound bag of couscous opened and not dated. An interview on 10/24/2017 at 10:00 AM with the Dietary Manager (DM) revealed they would not be using the tortilla shells and the opened bag of couscous was not on the new menu cycle. An observation on 10/24/2017 at 10:18 AM revealed 1 bag of pasta opened and not dated. An interview on 10/24/2017 at 10:20 AM with the DM revealed it was just opened and had been used this week. She stated the cooks were suppose responsible for the label and date on the bags when they open them and the dietary aides are responsible to go through dry storage and remove expired items. An observation on 10/24/2017 at 10:30 AM revealed three 5 pound bags of coleslaw mix dated use by 10/20/2017. These were in the refrigerator and available for use. An interview on 10/24/2017 at 10:40AM with the DM revealed they are using a new food company that is sending food that is close to the "don't use after date". An observation on 10/25/2017 at 3:49 PM revealed 5 packages of French toast in the freezer with no label including the name and date to use by on any of the packages. There was one opened package of hash browns and 15 closed bags of hash browns not labeled or dated. There were 5 bags of cauliflower with no label of what the item was or date to use by. There were two	F 371	identified a list of four residents and one guest on the 300 hall who had received the stuffed peppers for supper that were from the tray not heated to appropriate temperature. No other affected residents or visitors were identified. On 10/25/17, the nurse practitioner was notified and ordered the staff to monitor the four residents identified for signs of food borne illness q-2 hours for 8 hours, and then q-4 hours until 72 hours had passed since consumption. No signs or symptoms of food borne illness were noted for any of the four residents. On 10/26/17, dietary manager provided inservice education to dietary staff including cook #1 on following manufacturer guidelines for cooking temperatures, and assuring the food reaches the required internal temperature before serving. On 11/22/17 a worksheet was created to list potentially hazardous foods being prepared for a meal, the manufacturers required internal cooking temperature, and achieved cooking temperature for each pan of that food. Dietary staff were instructed to record the temperature to verify required temperature was achieved. Education was provided by the Dietary Manager on 10/26/17 regarding rotating stock using the first in, first out method, dating products, labeling products, and disposing of updated/expired products.	

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F 371	Continued From page 24 bags of a green pureed looking item with no label of what it was or date to use by. An interview on 10/25/2017 at 3:49 PM with the DM revealed the green item was guacamole. She stated they take the item out of the boxes they come in which have the products name and date to make more shelf space. They put the items to be used first in the front on the shelves. An interview on 10/26/2017 at 4:36 PM with the DM revealed her expectation was that all items in all in storage areas were labeled with the name, of the item and the date opened. She expected that any expired items would be removed from the storage area. I expect the dietary aides to do first in and first out when using the products. An interview by phone on 10/26/2017 at 5:04 PM with Dietary Aide #1 revealed she emptied trucks and put food in the refrigerators and freezers. She put the new things to the back and the items that needed to be used to the front. She stated the cooks label the things they use and take out of the boxes. She stated she went through things daily to check the dates. She stated the removed things that were expired. She stated she did not see that use by dates on the coleslaw. An interview on 10/26/2017 5:43 PM with Cook #1 revealed he sealed and dated any items he opened. He labeled a tray with the name and date if he took items out of the box. He stated he tried to check dates as he used items to make sure they were in date. He stated he put the name, date and his initials on the items. An interview on 10/26/2017 at 6:17 PM with the Administrator revealed her expectation was that	F 371	3. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency remains corrected and/or in compliance with regulatory requirements: Beginning 11/20/17, Dietary manager or assigned cook will audit dates and labels weekly on an ongoing basis to ensure expired foods are discarded timely. Dietary manager will audit temperature logs to assure that internal temperatures are achieved for potentially hazardous food products on each scheduled work day. Any noncompliant areas discovered during audits will be addressed with the dietary staff during that time. Effective Nov. 21st, 2017, audit findings for cooking temperatures per manufacturer guidelines, and labeling and dating of foods will be reported by the Dietary Director to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director). The QA Committee will review, discuss, and implement any necessary changes as indicated. 4. The title of the person responsible for implementing the acceptable plan of	

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F 371	Continued From page 25 all products in storage were labeled and dated doe proper storage. 2. Review of the manufacture's cooking instructions for the product (stuffed green peppers in tomato sauce) revealed their cooking instructions should be followed for food safety and quality. The item (stuffed green peppers) should be cooked thoroughly. It stated the internal temperature needs to reach 165 degrees Fahrenheit as measured by a food thermometer. It stated read and follow these cooking instructions. An observation on 10/25/2017 at 4:32 PM of the tray line revealed stuffed peppers were being served for dinner. An interview on 10/25/2017 at 4:32 PM with Cook #1 revealed the stuffed peppers were precooked and the DM stated to him the temperature for this item should be between 140 degrees Fahrenheit and 150 degrees Fahrenheit. An observation on 10/25/2017 4:48 PM of the temperatures of the stuffed peppers for the last tray being used was 150 degrees Fahrenheit. An interview on 10/25/2017 at 4:48 PM with the DM revealed the DM had not read the cooking instructions on the product label for the stuffed peppers. An interview on 10/25/2017 at 5:04 PM with Cook #1 revealed he had not seen the label with the cooking instructions for the product that stated the product should be cooked thoroughly to an internal temperature of 165 degrees Fahrenheit as measured by a food thermometer. He stated	F 371	correction is the Administrator. The Administrator will be responsible to ensure implementation of this Plan of Correction and ensure that the plan is followed with verification by the Regional Nurse Consultant and Regional Director of Operations during facility visits.	

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3.5 pans had been served to the residents. The first three trays were at the temperature per the product label and cooking instructions on it.

An interview on 10/25/2017 at 5:13 PM with the DM she had called the food suppliers representative for clarification regarding cooking this product and if the product was precooked.

An interview on 10/25/2017 at 6:12 PM with Cook #1, the DM and the Administrator revealed Cook #1 had followed the cooking instructions for a frozen product. The DM stated she thought the product was precooked since this item (stuff peppers) from their previous food supplier was precooked so she thought this item from the new supplier would be the same, precooked. The Administrator stated they had requested an immediate response from the food supplier regarding this product. The DM stated they thought it was precooked so she thought holding it on the steam table between 140-150 degrees was acceptable. Cook #1 stated this had never happened before. The DM identified a list of residents (4) and 1 guest on the 300 hall who had received the stuffed peppers for supper that were from the last tray not heated to 165 degrees Fahrenheit.

On 10/25/2017 at 6:40 PM the Administrator provided additional product information she had received that stated the product was stuffed with precooked beef.

An interview on 10/26/2017 at 11:56 AM Nurse Aide (NA) #2 On the 300 hall stated the resident she was caring who had eaten the product that was served from the last pan of food not cooked per product instructions had not expressed any

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concerns to her.

An interview on 10/26/2017 at 12:01 PM Nurse #3 on the 300 hall stated the resident on her hall who had eaten the product at dinner the night before was out for an appointment and had offered no concerns or signs and symptoms of not feeling well.

An interview on 10/26/2017 at 12:03 PM Nurse #4 on the 300 hall the resident who had the food at dinner last night offered no complaints and was out with her husband today. She had no nausea, diarrhea or other complaints.

An interview on 10/26/2017 12:06 PM Nurse# 5 on the 300 hall stated the resident who had received the stuffed peppers for dinner last night was for a treatment and was fine today. She received her medications this morning and had no problems with nausea or vomiting. We followed the orders in the computer regarding monitoring the residents who had received the stuff peppers at dinner last night. We did that.

A review of the Dietician's note dated 10/26/2017 at 12:51 PM noted that the resident had eaten a few bites of the stuff peppers not brought to 165 degrees per package instructions with no adverse impact reported and was being monitored for any potential food borne illness.

An interview on 10/26/2017 at 3:39 PM with the Nurse Practitioner (NP) #1 revealed if there were any concerns the staff would put them in the communication book for her to see the residents. If there are other issues they staff call the on call provider. I had not received any notifications today that there were any issues regarding food

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eaten last night at dinner or residents who had nausea, diarrhea or fevers.

An interview on 10/26/2017 at 4:36 PM with the DM revealed her expectation was that the cooks would follow the manufacturer's cooking instructions on the product labels when cooking products for meals.

An interview on 10/26/2017 at 4:51 PM with Nurse #2 on the 300 hall revealed the residents who were served the stuff peppers were fine last night. They were monitored for any adverse effects from the dinner meal. No medications were given for nausea or diarrhea to those residents last evening.

An interview on 10/26/2017 6:03 PM with the Director of Nursing (DON) revealed she had been notified of the problem with the dinner meal stuff peppers. She notified NP #2 who was on call and entered orders for observation and monitoring of the 4 residents who had received the stuff peppers from the last tray that had not reached the recommended cooking temperature per the product cooking instructions. She instructed the nursing staff regarding monitoring of these residents. She stated that there were no concerns through the night or day today with these resident. She received a report that all the residents had slept through the night last night and were going about their usual activities today.

An interview on 10/26/2017 at 6:17 PM with the Administrator revealed her expectation was that all regulations and ServSafe would be followed. She expected when staff were cooking products/items the directions per the manufacturer cooking instructions would be

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F 371	Continued From page 29 followed to cook them to the correct temperature especially if it was a new item being prepared.	F 371		