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	345305	A. BUILDING _____ B. WING _____	C 12/05/2019

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SMOKY RIDGE HEALTH & REHABILITATION	310 PENSACOLA ROAD BURNSVILLE, NC 28714

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 12/02/19 through 12/05/19. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID #TBOU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 12/02/19 to 12/05 19. A total of 6 allegations were investigated and one was substantiated. Event ID #TBOU11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		1/2/20

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

Electronically Signed | 12/24/2019

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to maintain clean privacy curtains for 1 of 12 resident rooms on 300 hall (room 313), failed to properly label and store personal care equipment in 1 of 9 bathrooms (bathroom in room 402), failed to maintain a clean and sanitary geriatric chair for 1 of 1 geriatric chair, failed to maintain a clean floor in 1 resident room and bathroom (room 314), failed to maintain clean and sanitary floors and baseboards for 2 of 4 halls (300 and 400 halls), failed to maintain clean walls on 2 out of 4 halls (300 and 400 hall), and failed to maintain clean and sanitary doors (300 hall) for 1 of 4 halls. Findings included: A. An observation of room 313 on 12/02/19 at 9:11 AM revealed both privacy curtains had brown stains on them.	F 584	(1)The facility failed to maintain clean privacy curtain for 1 of 12 resident rooms on 300 (room 313), failed to properly label and store personal care equipment in 1 of 9 bathrooms (bathroom 402), failed to maintain a clean and sanitary geriatric chair for 1 of 1 geriatric chair, failed to maintain a clean floor in 1 resident room and bathroom (room 314), failed to maintain clean and sanitary floor in baseboards for 2 of 4 halls (300 and 400 halls), failed to maintain clean walls on 2 out of 4 halls (300 and 400 hall), failed to maintain clean and sanitary doors (300 hall) for 1 of 4 halls. Staff Development coordinator began in-servicing 12/5/19 to all staff to ensure compliance with policy and expectations related to proper housekeeping were met; related to interventions applied to provide a safe, clean, comfortable, homelike	

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F 584	Continued From page 2 An observation of room 313 on 12/03/19 at 3:30 PM revealed both privacy curtains had brown stains on them. An observation of room 313 on 12/04/19 at 8:54 AM revealed both privacy curtains had brown stains on them. An observation of room 313 on 12/05/19 at 8:28 AM revealed both privacy curtains had brown stains on them. An interview with the Director of Nursing (DON) on 12/05/19 at 9:15 AM revealed the privacy curtains should be clean and free of stains. She stated when staff see a visibly soiled privacy curtain they should report it to housekeeping so they can replace it. B. An observation of the shared bathroom of room 402 on 12/02/19 at 11:59 AM revealed 2 unlabeled bed pans were stored in the same bag hanging from the handrail and 2 unlabeled toothbrushes and an unlabeled hairbrush were stored in a clear container on the sink. An observation of the shared bathroom of room 402 on 12/03/19 at 3:16 PM revealed 2 unlabeled bedpans were stored in the same bag hanging from the handrail and 2 unlabeled toothbrushes and an unlabeled hairbrush were stored in a clear container on the sink. An observation of the shared bathroom of room 402 on 12/04/19 at 8:50 AM revealed 2 unlabeled bedpans were stored in the same bag hanging from the handrail and 2 unlabeled toothbrushes and an unlabeled hairbrush were stored in a clear container on the sink.	F 584	environment. Room 313 privacy curtain was replaced immediately. All other rooms were checked to identify if any other privacy curtained needed to be replaced and replaced as needed. The toothbrush, personal items, and bed pan in bathroom of 402 where disposed of immediately and items replaced with resident specific labels in individual receptacles. The geriatric chair was deep cleaned 12/5/19 per the cleaning schedule completed by 11-7 staff. The floor in resident room 314 was cleaned immediately. Residents in A and B bed were temporarily relocated and the floor stripped and waxed 12/5/19. Housekeeping staff were immediately assigned 12/5/19 to cleanse baseboards, walls and doorways initially to 300 and 400 hall, and then through the facility to ensure compliance. (2)All residents have the potential to be affected. Facility rounds have been assigned to all administrative staff. Housekeeping rounds and deep cleansing schedule reviewed and revised as indicated. Administrator/DON and Housekeeping Supervisor will audit all room rounds and deep cleaning schedules to ensure compliance established. Administrator/DON or designee will round daily (3)DON/ADON & SDC began immediate in-servicing on 12/5/19/ and educations were completed on 12/18/19 for all staff related to the procedure and expectation to maintain safe, clean, comfortable	

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F 584	Continued From page 3 An observation of the shared bathroom of room 402 on 12/05/19 at 8:29 AM revealed 2 unlabeled bedpans were stored in the same bag hanging from the handrail and 2 unlabeled toothbrushes and an unlabeled hairbrush were stored in a clear container on the sink. An interview with the DON on 12/05/19 at 9:17 AM revealed the toothbrushes and hair brush should be labeled and the bedpans should have been labeled and bagged separately. She stated staff should have noticed the unlabeled items and the bed pans bagged together when room rounds were done daily. C. An observation of Resident #78's geriatric chair on 12/02/19 at 2:59 PM revealed dried food on the right arm rest and right side of the chair. An observation of Resident #78's geriatric chair on 12/03/19 at 3:13 PM revealed dried food on the right arm rest and right side of the chair. An observation of Resident #78's geriatric chair on 12/04/19 at 9:44 AM revealed dried food on the right arm rest and right side of the chair. An observation of Resident #78's geriatric chair on 12/05/19 at 8:15 AM revealed dried food on the right arm rest and right side of the chair. An interview with the DON on 12/05/19 at 9:20 AM revealed geriatric chairs should be clean and free of dried food. She stated third shift cleaned chairs every week and Resident #78's geriatric chair was last cleaned 11/28/19. D. An observation of room 314 on 12/03/19 at	F 584	homelike environment are met. Deep cleaning schedule will include 10-15 rooms weekly and be ongoing thereafter. Stripping and waxing of the facility floors schedule will include1 room weekly until all rooms are completed. Rooms in greatest need will be determined by room rounds. 300 hall and 400 hall to be stripped and waxed by January 2nd, 2019 with replacement of baseboards at time of stripping hallways. Each other hall in facility will be stripped and waxed with baseboards replaced as needed. Administrator/DON and Housekeeping Supervisor/designee will complete audit of room rounds and deep cleaning reports, 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Each housekeeping staff member hired after this date will be provided with a signed education regarding policy and expectation related to facility cleaning and follow through to reflect safe, clean, comfortable, homelike environment to ensure compliance. (4)Housekeeping/designee will complete audit of facility room rounds and deep cleaning schedules for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting to maintain compliance The Administrator (LNHA) is responsible for overall compliance. The DON/designee will present results of	

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F 584	Continued From page 4 3:22 PM revealed the floor of the room and bathroom was sticky. An observation of room 314 on 12/04/19 at 8:55 AM revealed dried shoe prints on the floor of the room and the floor of the shared bathroom of 314 was sticky. An observation of room 314 on 12/05/19 at 8:23 AM revealed the floor of the room and bathroom were sticky. An interview with the Housekeeping Supervisor on 12/05/19 at 9:05 AM revealed rooms were swept and mopped daily. The Housekeeping Supervisor stated there was a stomach bug in the facility last month and housekeeping staff were using bleach to clean. He stated it was possible the bleach had taken the wax off the floor in room 314 and made the floor sticky. The Housekeeping Supervisor stated rooms get deep cleaned every 2 weeks and he cleaned room 314 on 12/03/19. He stated he had planned on waxing the floors in the facility but had not gotten to it. E. An observation of the 300 hall on 12/04/19 at 9:11 AM revealed stains and debris on the baseboards on both sides of the hall from the top of the hall and continuing to the end of the hall. An observation of the lower part of the 300 hall wall at the same date and time revealed scuff marks from the beginning of the 300 hall and continuing to the end of the hall on both side of the hall. An observation of the double doors on 300 hall at the same date and time revealed dried material on both doors. An observation of the floor on 300 hall at the same date and time revealed dirt and debris where the floor meets the baseboards along the entire length of 300 hall.	F 584	audits to the QAPI committee. (5) The facility will be in compliance as of 01/02/2020.	

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F 584	Continued From page 5	F 584		

An observation of the 300 hall baseboards on 12/05/19 at 8:25 AM revealed stains and debris on the baseboards on both sides of the hall from the top of the hall and continuing to the end of the hall. An observation of the lower part of the 300 hall wall revealed scuff marks from the beginning of the 300 hall and continuing to the end of the hall on both side of the hall and the double doors on 300 hall had dried material on both doors. An observation of the floor on 300 hall revealed dirt and debris where the floor meets the baseboards along the entire length of 300 hall.

An interview with the Housekeeping Supervisor on 12/05/19 at 9:20 AM revealed there was no cleaning schedule for the baseboards or double doors but they needed to be cleaned. He stated he had planned on stripping and waxing the floors but he had not gotten around to it. The Housekeeping Supervisor stated the floors are usually stripped and wax the floor once a year close to Christmas. He stated he had talked with the Administrator about painting the walls but he had not gotten to it yet and they had not picked out a color.

An interview with the Administrator on 12/05/19 at 9:22 AM revealed she had talked with the Housekeeping Supervisor about painting the walls on 300 and 400 halls but they had not picked out a color yet. She stated the housekeeping staff had not gotten around to waxing and stripping the floor because they were in the process of trying to get a grant to turn the 400 hall into a memory care unit and they were focused on getting the grant instead of the floors.

F. An observation of 400 hall on 12/04/19 at 9:15

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F 584	Continued From page 6	F 584		

AM revealed stains and debris on the baseboards on both sides of the hall from the top of the hall and continuing to the end of the hall. An observation of the floor on 400 hall revealed dirt and debris where the floor meets the baseboards along the entire length of 400 hall. An observation of the lower wall on 400 hall revealed a scuff mark extending from room 412 to room 414.

An observation of 400 hall on 12/05/19 at 8:26 AM revealed stains and debris on the baseboards on both sides of the hall from the top of the hall and continuing to the end of the hall. An observation of the floor on 400 hall revealed dirt and debris where the floor meets the baseboards along the entire length of 400 hall. An observation of the lower wall on 400 hall revealed a scuff mark extending from room 412 to room 414.

An interview with the Housekeeping Supervisor on 12/05/19 at 9:20 AM revealed there was no cleaning schedule for the baseboards but they needed to be cleaned. He stated he had planned on stripping and waxing the floors but he had not gotten around to it. The Housekeeping Supervisor stated the floors were usually stripped and wax the floor once a year close to Christmas. He stated he had talked with the Administrator about painting the walls but he had not gotten to it yet and they had not picked out a color yet.

An interview with the Administrator on 12/05/19 at 9:22 AM revealed she had talked with the Housekeeping Supervisor about painting the walls on 300 and 400 halls but they had not picked out a color yet. She stated the housekeeping staff had not gotten around to

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F 584	Continued From page 7 waxing and stripping the floor because they were in the process of trying to get a grant to turn the 400 hall into a memory care unit and they were focused on getting the grant instead of the floors.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in area of Hospice to reflect prognosis (Resident #74 and #27) and area of Preadmission Screening and Resident Review (PASARR) to reflect Level II determination for (Resident #6). Findings included: 1. Resident #74 was admitted to the facility on 08/14/18 with diagnosis of cancer. A review of a Hospice Certification Statement with effective date of 05/26/19 and ending date of 08/23/19 signed by the physician on 06/06/19 indicated Resident #74 had a terminal illness with a life expectancy of six months or less for diagnosis of malignant neoplasm (new growth tissue) of prostate. A review of a Hospice Recertification Statement with effective date of 08/24/19 and ending date of 11/21/19 signed by the physician on 08/21/19 indicated Resident #74 had a terminal illness with a life expectancy of six months or less for	F 641	(1)The facility failed to accurately code the Minimum Data Set (MDS) in area of Hospice to reflect prognosis (Resident #74 and #27) and area of Preadmission Screening and Resident Review (PASARR) to reflect Level II determination for (Resident #6). Proper documentation obtained from Hospice entities 12/3/19 and MDS were modified to correct coding of section J and O and resubmitted. Corrections were provided to surveyors 12/3/19 day of resubmission. The Preadmission Screening and Resident Review (PASARR) Section A for resident #6 was modified and resubmitted. Corrections provided to surveyor 12/3/19 day of resubmission. Clinical Nurse Educator began in-servicing to MDS nursing staff 12/3/19 and completed 12/18/19 to ensure compliance with policy and expectations were met; related to correct coding of sections A, J, and O of the MDS. All Hospice recipients and Level II PASARR patient□s MDS were reviewed to ensure proper coding and compliance.	1/2/20

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F 641	Continued From page 8 diagnosis of malignant neoplasm of prostate. A review of 2 separate significant change MDS assessments dated 06/06/19 and 11/08/19 indicated under Section J1400 Prognosis that Resident #74 was not coded as having a chronic condition that might result in life expectancy of less than 6 months. On 12/03/19 at 1:38 PM an interview was conducted with MDS Nurse #1 who stated she was responsible for coding Section J1400 Prognosis on Resident #74's significant change MDS assessment dated 06/06/19 and 11/08/19. MDS Nurse #1 revealed she did not code that Resident #74 had a life expectancy of less than 6 months because the Hospice Certification for significant change MDS dated 06/06/19 and Hospice Recertification for significant change MDS assessment dated 11/08/19 were not available in the medical record when she completed the assessment. MDS Nurse #1 revealed a modification of the significant change MDS assessment dated 06/06/19 and 11/08/19 would need to be submitted to accurately reflect Resident #74 had a life expectancy less than 6 months. On 12/03/19 at 2:09 PM an interview was conducted with MDS Nurse #2 who revealed she had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code Section J1400 Prognosis. MDS Nurse #2 revealed a modification of the significant change MDS assessment dated 06/06/19 and 11/08/19 would need to be submitted to accurately reflect Resident #74 had a life expectancy less than 6 months.	F 641	(2)All residents with Hospice terminal diagnosis and Level II PASARR have the potential to be affected. An initial audit of all active resident MDS and care plans reviewed and updated as indicated for residents with Hospice services and Level II PASARR. (3)DON/ADON & SDC began immediate in-servicing on 12/3/19 and educations were completed on 12/18/19 for licensed nursing staff related to the procedure and expectation regarding proper coding of the MDS to ensure documentation and follow-up are met. DON/Designee will audit MDS prior to submission to ensure correct coding of section A, J, O is reflected on the MDS and documentation is present as indicated. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit of MDS for accuracy of coding 5 x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to clinical documentation and follow t through to reflect accuracy of the medical record to ensure compliance. (4)DON/Designee will report findings for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed	

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F 641	Continued From page 9 On 12/03/19 at 2:47 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the significant change MDS assessments would have been accurately coded to reflect Resident #74 had a life expectancy less than 6 months. The DON indicated there may have been confusion of the interpretation of the RAI manual for MDS Nurse #1 to code Section J1400 Prognosis on the significant change MDS assessment dated 06/06/19 and 11/08/19. On 12/03/19 at 3:01 PM an interview was conducted with the Administrator who indicated her expectation was that the significant change MDS assessments would have been accurately coded to reflect Resident #74 had a life expectancy less than 6 months. The Administrator stated she felt the inaccurate coding of Section J1400 Prognosis was related to MDS Nurse #2 misinterpretation of the RAI manual for coding prognosis. 2. Resident #27 was admitted to the facility on 07/27/17 with Alzheimer's dementia. A review of a Hospice Certification Statement with effective date of 09/13/19 and ending date 12/11/19 signed by the physician on 09/19/19 indicated Resident #27 had a terminal illness with a life expectancy of six months or less for diagnosis of Alzheimer's disease. A review of a significant change Minimum Data Set (MDS) assessment dated 09/25/19 indicated under Section J1400 Prognosis that Resident #27 was not coded as having a chronic condition that might result in life expectancy of less than 6 months.	F 641	every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. The DON/ADON is responsible for overall compliance. (5) The facility will be in compliance as of 01/02/2020.	

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F 641	Continued From page 10 On 12/03/19 at 1:57 PM an interview was conducted with MDS Nurse #1 who stated she was responsible for coding Section J1400. Prognosis on Resident #27's significant change MDS assessment dated 09/25/19. MDS Nurse #1 revealed she did not code that Resident #27 had a life expectancy of less than 6 months because the Hospice Certification statement was not available in the medical record when she completed the significant change MDS assessment. MDS Nurse #1 revealed a modification of the significant change MDS assessment dated 09/25/19 would need to be submitted to accurately reflect Resident #27 had a life expectancy less than 6 months. On 12/03/19 at 2:09 PM an interview was conducted with MDS Nurse #2 revealed she had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code Section J1400. Prognosis. MDS Nurse #2 revealed a modification of the significant change MDS assessment dated 09/25/19 would need to be submitted to accurately reflect Resident #27 had a life expectancy less than 6 months. On 12/03/19 at 2:47 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the significant change MDS assessment would have been accurately coded to reflect Resident #27 had a life expectancy less than 6 months. The DON indicated there may have been confusion of the interpretation of the RAI manual for the MDS Nurse #1 to code Section J1400 Prognosis on the significant change MDS assessment dated 09/25/19.	F 641		

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F 641	Continued From page 11	F 641		

On 12/03/19 at 3:01 PM an interview was conducted with the Administrator who indicated her expectation was that the significant change MDS assessment would have been accurately coded to reflect Resident #27 had a life expectancy less than 6 months. The Administrator stated she felt the inaccurate coding of Section J1400. Prognosis was related to the MDS Nurse #2 misinterpretation of the RAI manual for coding prognosis.

3. Resident #6 was admitted to the facility on 01/17/12 with diagnoses that included anxiety disorder and schizophrenia.

Record review indicated Resident #6 had a Level II Preadmission Screening and Resident Review (PASARR) dated 11/26/18.

The annual Minimum Data Set (MDS) dated 01/09/19 indicated a "NO" to question A1500 which asked if Resident #6 had been evaluated by a Level II PASARR and determined to have a serious mental illness and/or intellectual disability or related condition.

An interview was conducted with MDS Nurse #1 on 12/04/19 at 1:30 PM. MDS Nurse #1 confirmed Resident #6 was a Level II PASARR and the MDS dated 1/09/19 was coded incorrectly. She stated it was just keyed wrong, and that she would modify and correct the assessment.

An interview was conducted with the Director of Nursing (DON) on 12/04/19 at 3:12 PM. She indicated that it was her expectation for the MDS assessment to be coded accurately to identify the

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F 641	Continued From page 12 resident as a Level II PASARR. An interview with the Administrator on 12/04/19 at 4:29 PM revealed that that she felt the MDS assessment was keyed incorrectly. She stated that she expected assessment documentation to be accurate and correct.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		1/2/20

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F 690	Continued From page 13 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, hospice nurse, and nurse practitioner interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 2 residents reviewed for hospice (Resident #74). The findings included: Resident #74 was admitted to the facility on 08/14/18 with diagnoses of cancer and benign prostatic hypertrophy (BPH). A significant change Minimum Data Set (MDS) assessment dated 11/08/19 indicated Resident #74 was cognitively impaired, was total dependent for transfers, toileting, personal hygiene, and required an indwelling catheter. A review of Resident #74's care plan with revision date of 11/08/19 addressed a urinary problem which indicated Resident #74 had an indwelling urinary catheter related to diagnoses of BPH, obstructive uropathy (urinary disease), and prostate cancer. The goal specified Resident #74 would have no injury secondary to catheter manipulation. The approaches indicated staff were to change catheter every month and secure catheter to thigh to prevent pulling on catheter tubing. An interview was conducted on 12/02/19 at 3:28	F 690	(1)The facility failed to secure indwelling urinary catheter tubing for 1 of 2 residents reviewed for hospice (Resident #74). Leg securing device obtained and placed 12/3/19 to thigh of resident # 74 to prevent injury secondary to catheter manipulation. Staff Development Nurse Educator began in-servicing to nursing staff 12/3/19 and completed 12/18/19 to ensure compliance with policy and expectations were met; related to Catheter Care policy and procedure. All residents with catheters were re-evaluated for placement of catheter securing device to ensure compliance. (2)All residents with indwelling Foley catheters have the potential to be affected. A review of all active residents with indwelling Foley catheters were reviewed and replaced as indicated for residents with indwelling Foley catheters requiring leg securing device to prevent injury secondary to catheter manipulation. Care plans for those with indwelling Foley catheters were reviewed and modified to reflect use or refusal of catheter securing device. (3)DON/ADON & SDC began immediate in-servicing on 12/3/19 and 100% of	

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F 690	Continued From page 14 PM with Nurse Aide (NA) #1 who stated Resident #74 did not have a catheter securing device on his thigh. NA #1 stated she had never applied a catheter tubing securing device to Resident #74's thigh to prevent pulling on the catheter tubing. On 12/03/19 at 3:30 PM an observation was conducted with of Nurse #1 while she assessed Resident #74 which revealed Resident #74 did not have a catheter securing device in place on his thigh to prevent pulling on the catheter tubing. Resident #74 did not have any observed signs of bleeding from the urethral meatus (opening) related to the absence of catheter securing device. Nurse #1 indicated Resident #74 should have had a catheter securing device. On 12/03/19 at 3:59 PM an interview was conducted with the Treatment Nurse (TN) who stated per the treatment administration record (TAR) Resident #74's catheter bag and tubing were to be changed monthly which included changing the catheter securing device. The TN stated it was the responsibility of the TN to assure catheter securing device was in place to secure Resident #74's catheter tubing. The TN indicated Resident #74 should have had a catheter securing device to prevent pulling on the catheter tubing and the securing device was missed. The TN indicated Resident #74 wanted a catheter tubing securing device and the TN immediately applied a catheter tubing securing device. On 12/03/19 at 4:08 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #74 would have had a catheter tubing securing device per facility policy. The DON indicated it was the responsibility of the TN to assure	F 690	educations completed on 12/18/19 for licensed and non-licensed nursing staff related to the procedure and expectation regarding proper catheter care and placement of catheter securing device to prevent injury secondary to catheter manipulation are met. DON/Designee will audit placement of catheter securing device placement as indicated for residents with indwelling Foley catheters. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit of catheter securing device for those with use of indwelling Foley catheters 5x a week x 4 weeks, weeks, weekly x 4 weeks then monthly x 3. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to catheter care and leg securing device placement to ensure compliance. (4)DON/Designee will audit catheter securing device placement as indicated for residents with indwelling Foley catheters for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. (5) The facility will be in compliance as of 01/02/2020.	

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F 690	Continued From page 15 Resident #74 had a catheter securing device in place to prevent pulling on the indwelling catheter tubing. The DON stated the treatment nurse failed to monitor that Resident #74 had a catheter tubing securing device. On 12/03/19 at 4:40 PM an interview was conducted with the Administrator who stated her expectation was that Resident #74 would have had an indwelling catheter tubing securing device to prevent pulling on catheter tubing per facility policy. The Administrator stated the treatment nurse missed checking to assure Resident #74 had a catheter tubing securing device. On 12/04/19 at 8:41 AM a telephone interview was conducted with the Nurse Practitioner (NP) who stated her expectation was that Resident #74 would have a catheter tubing securing device in place to prevent pulling on the catheter tubing. The NP stated even with a securing device in place the catheter tubing could still be pulled but the securing device would minimize the pulling on the catheter tubing. On 12/04/19 at 9:05 AM a telephone interview was conducted with the hospice nurse who stated her expectation was that Resident #74 would have a catheter tubing securing device in place to prevent pulling of catheter tubing.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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	F 761		1/2/20

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F 761	Continued From page 16 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 failed to date an opened multi-use bottle of tuberculin purified protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. Findings included: An observation of the North medication room refrigerator on 12/04/19 at 4:13 PM revealed an opened but undated multi-use 1 milliliter (ml) bottle of PPD solution. An interview with the Assistant Director of Nursing (ADON) on 12/04/19 at 4:13 PM revealed the 1 ml bottle of PPD solution should have been dated when it was opened. The ADON stated the	F 761	(1)The facility failed to date an opened multi-use bottle of tuberculin purified protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. The PPD vial was immediately discarded in appropriate receptacle and removed from use. Staff Development Nurse Educator began in-servicing to nursing staff 12/4/19 and completed 12/18/19 to ensure compliance with policy and expectations were met; related to labeling and storage of medications policy and procedure. Both medication storage rooms were re-evaluated to ensure compliance.	

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F 761	Continued From page 17 Nurse Supervisors checked the medication carts, medication refrigerators, and medication rooms for outdated or undated medications weekly and the medication refrigerator was last checked 12/02/19. An interview with the Director of Nursing (DON) on 12/05/19 at 9:58 AM revealed the PPD solution should have been dated when it was opened. She stated the process for checking for expired or undated medications was for the Nurse Supervisors to check the medication carts, medication refrigerators, and medication rooms for expired or undated medications weekly and the medication refrigerator was last checked the morning of 12/02/19. The DON said the undated bottle of PPD solution was just overlooked when the mediation refrigerator was checked on 12/02/19. An interview with the Administrator on 12/05/19 at 9:59 AM revealed she expected the nurse who opened the bottle of PPD solution to have dated the medication at the time it was opened or the person assigned to check the medication refrigerator to have either dated or discarded the medication.	F 761	(2)All residents receiving PPD injections have the potential to be adversely affected. A review of medication storage rooms were re-evaluated to ensure compliance met with labeling and storage of medications. (3)DON/ADON & SDC began immediate in-servicing on 12/4/19 and 100% of educations completed on 12/18/19 for licensed nursing staff related to labeling and storage of medications policy and procedure. DON/Designee will audit medication storage locations. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to labeling and storage of medications to ensure compliance. (4)DON/Designee will review audited medication rooms for labeling and storage of medications monthly x 3, for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. (5) The facility will be in compliance as of 01/02/2020.	

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F 867	Continued From page 18	F 867		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 11/16/18. This was for one recited deficiency that was originally cited in November 2018 and subsequently recited on the current recertification and complaint investigation of 12/05/19. The recited deficiency was in the area of accuracy of assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-641- Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in area of Hospice to reflect prognosis (Resident #74 and #27) and area of Preadmission Screening and Resident Review (PASARR) to reflect Level II determination for (Resident #6).	F 867	(1)The facility□s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey 11/16/18. This was for one recited deficiency that was originally cited in November 2018 and subsequently recited on the current recertification and complaint investigation 12/5/19. The recited deficiency was in the area of accuracy of assessments The facility failed to accurately code the Minimum Data Set (MDS) in area of Hospice to reflect prognosis (Resident #74 and #27) and area of Preadmission Screening and Resident Review (PASARR) to reflect Level II determination for (Resident #6). The MDS for residents #74, #27, and #6 were modified and resubmitted after corrections made to the MDS. Regional Director of Operations in-serviced LNHA and DON 12/11/19 and interdisciplinary team 12/12/19 to ensure compliance with policy and expectations were met; related to QAPI/QAA to ensure compliance.	1/2/20

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F 867	Continued From page 19 During the annual recertification survey of 11/16/18 the facility was cited for failure to accurately code the MDS assessment to reflect Level II PASRR determination for a resident identified as PASRR Level II. 12/05/19 at 10:24 AM an interview was conducted with the Administrator who indicated there was a process in place to monitor accuracy of coding PASRR Level II determination and the coding had improved so the oversight process was stopped. The Administrator shared the PASRR Level II determination was just missed for coding and a monitoring system for coding PASRR would be implemented.	F 867	(2)All residents have the potential to be adversely affected in the area of accuracy of assessments. (3)The Administrator and Director of Nursing were educated by the Regional Director of Operations on the facilities Quality Assurance Performance Improvement program (QAPI) on 12/11/19. The education included identifying areas of continuous quality monitoring and the tools to be used. The Director of Nursing educated facilities interdisciplinary team 12/12/19 regarding the policy and procedures on the QAPI program. Education also included monitoring activities, a focus on the processes that effect resident outcomes and performance improvement. Ongoing monitoring will be used to re-establish the facilities outcomes. DON/ADON & SDC began immediate in-servicing on 12/5/19 and 100% of educations completed on 12/18/19 for licensed nursing staff related QAPI/QAA policy and procedure. The Administrator is accountable for the overall implementation and functioning of the QAPI program. The QAPI committee will meet monthly to continue to monitor and identify areas of improvement to include survey deficiencies. The Committee will address the identified needs through improvement, action plans and monitoring the effectiveness of such plans. The Regional Director of Operations (RDO) will review the facility QAPI Committee meeting minutes for up to six months to ensure ongoing compliance.	

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F 867	Continued From page 20	F 867	(4)The QAPI committee will meet monthly to continue to monitor and identify areas of improvement to include survey deficiencies. The Committee will address the identified needs through improvement, action plans and monitoring the effectiveness of such plans. The Regional Director of Operations(RDO) will review the facility QAPI Committee meeting minutes for up to six months to ensure ongoing compliance. (5) The facility will be in compliance as of 01/02/2020.	