STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(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 A Recertification and complaint survey was conducted from 02/27/2018 through 03/08/2018. On 03/07/18 surveyors returned to the facility to conduct an extended survey. The survey's exit date was expanded from 03/02/18 to 03/08/18 to accommodate the extended survey. Event ID# 86XQ11. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (J). Immediate Jeopardy began on 02/27/2018 and was removed on 03/08/2018. Event ID# 86XQ11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		4/8/18

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

Electronically Signed | 03/28/2018

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F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director (MD) interview the facility failed to notify the MD of blood sugar levels outside the ordered range acceptable for Resident #3. This was evident in 1 of 1 resident reviewed for notification of MD. Findings included:	F 580	The facility wishes to have this submitted plan of correction stand as its written allegation plan of compliance. Our date of compliance is April 8, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or	

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F 580	Continued From page 2 Resident #3 was admitted to the facility on 09/08/16 with diagnoses which included diabetes. Record review of the physician's orders for Resident #3 indicated an order for Novolog (insulin) with a start date of 12/13/17 and no end date. The order indicated the following: Novolog insulin injected according to finger stick blood sugars (FSBS obtained by testing a drop of blood) with notification of the MD if the FSBS was 0-69 (low) or 401 (high) or above. FSBS was to be obtained at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM for Resident #3 before administering sliding scale insulin. Record review of the Medication Administration Record (MAR) for February 2018 indicated no documentation the MD had been notified for the following FSBS levels: 02/05/18 at 4:30 PM - FSBS of 68 02/06/18 at 4:30 PM - FSBS of 66 02/09/18 at 4:30 PM - FSBS of 63 02/11/18 at 7:30 AM - FSBS of 65 02/11/18 at 4:30 PM - FSBS of 61 02/12/18 at 8:00 PM - FSBS of 51 02/13/18 at 7:30 AM - FSBS of 68 02/15/18 at 4:30 PM - FSBS of 64 02/18/18 at 7:30 AM - FSBS of 64 02/19/18 at 4:30 PM - FSBS of 61 02/20/18 at 4:30 PM - FSBS of 60 02/22/18 at 8:00 PM - FSBS of 69 02/24/18 at 7:30 AM - FSBS of 69 02/24/18 at 4:30 PM - FSBS of 61 02/25/18 at 7:30 AM - FSBS of 63 02/27/18 at 7:30 AM - FSBS of 64 During an interview on 03/01/18 at 9:34 AM the Director of Nursing (DON) and Unit Manager	F 580	executed to ensure compliance with regulatory requirements. F580 Notify of Changes Corrective Action: It is duly noted that licensed nurses failed to notify MD of blood sugar levels below 60 for Resident #3 for the month of February 2018. Physician was notified of Resident #3□s blood sugar levels on the days in February 2018 that were not documented as notified per parameters. The notification parameters were reviewed with physician and orders were received to notify physician if blood sugar is less than 60 or greater than 450mg/dl. There was no negative outcome to resident. Corrective Action for those having the potential to be affected: Other residents with orders for notification parameters for blood sugar levels are potentially at risk. Notification parameters have been reviewed and orders for notification were reviewed and clarified. No other residents were identified that did not have proper physician notification per physician orders. Systematic Changes: Director of Nursing will educate licensed staff on sliding scale blood sugar checks, parameters for notification and notifying physician when checks indicate levels are outside the ordered acceptable range. Monitoring: Unit managers will audit records of those residents with blood sugar	

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F 580	Continued From page 3 were informed of the missing documentation of the MD being notified of the low FSBS and were asked to assist in locating this information. On 03/01/18 at 9:50 AM, the Unit Manager stated she and the DON had looked and had been unable to find instances where the MD was notified when Resident #3 had FSBS's of 69 or lower during February 2018. During an interview by phone with Nurse #1 on 03/01/18 at 10:24 AM, Nurse #1 stated she could not remember if she had contacted the doctor about Resident #3 regarding a low FSBS of 64 on 02/18/18. Nurse #1 also stated if she had contacted the doctor she would have documented it in nurses' notes. During an interview with Nurse #2 on 03/01/18 at 10:39 AM, Nurse #2 reviewed the MAR for February 2018 and verified Resident #3 had a low FSBS of 63 on 02/09/18 and 68 on 02/13/18. Nurse #2 also stated she could not recall if she had notified the MD on either of these dates, but it would have been in the nurses' notes if she had. Nurse #3 further stated she had spoken to the MD in the past about the highs and lows of the blood glucose level for Resident #3. During an interview with Nurse #3 on 03/01/18 at 10:52 AM, Nurse #3 reviewed the MAR for February 2018 and verified Resident #3 had low FSBS on 02/05/18 of 68, 02/06/18 of 66; 02/11/18 of 65; 02/15/18 of 64; 02/19/18 of 61; 02/20/18 of 60; 02/24/18 of 61 and 02/25/18 of 63. Nurse #3 stated she was not aware that the order indicated the MD was to be called for a FSBS of 69 or less. Nurse #3 also stated she had not notified the MD for any of the FSBS that were 69 or less. Nurse	F 580	notification parameters weekly for 4 months and then monthly for 6 months to determine compliance with physician notification of blood glucose parameters. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The administrator will be responsible to ensure any further recommendations are carried out.	

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F 580	Continued From page 4 #3 further stated she had written several notifications to the MD regarding FSBS issues for Resident #3, but she had not called the MD when the low FSBS occurred. During a phone interview with Nurse #4 on 03/01/18 at 12:45 PM, Nurse #4 stated she did not remember what the FSBS for Resident #3 had been on 02/27/18 in the AM, but if it was below 69 she should have contacted the MD and made a nurses' note, but she knew she did not do that. During an interview with the MD on 03/02/18 at 10:54 AM, the MD reviewed the February 2018 MAR for Resident #3. The MD stated that he had not been made aware when Resident #3 had low FSBS and if he had been made aware he would have adjusted her insulin. The MD also stated Resident #3 had no signs of hypoglycemic episodes that he had been made aware of and that no harm had occurred. During an interview with the DON on 03/02/18 at 6:43 PM, the DON stated her expectations were for the nurses to be following the MD orders and contacting the MD per the order.	F 580		
F 584 SS=D	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	F 584		4/8/18

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F 584	Continued From page 5 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; §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, resident, and staff interviews the facility failed to clean/sanitize a toilet with a moderate amount of brown matter on the back of a toilet lid, the toilet seat, and the wall beside the toilet for 1 of 13 bathrooms reviewed for a safe/clean/comfortable/homelike	F 584	F584 Safe/clean/comfortable/homelike environment Corrective Action: It is duly noted that Room 111 toilet had moderate amount of brown matter on back of toilet lid, the toilet seat, and the	

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F 584	Continued From page 6 environment (Room #111). Findings included: During an observation on 02/28/18 at 9:45 AM, the private bathroom of room #111 had a moderate amount of a brown colored matter dried to the back of toilet lid and toilet seat. There were approximately 20 splatter marks of brown matter on the wall beside toilet. During an interview on 02/28/18 at 9:45 AM, cognitively intact Resident #49 explained on 02/27/18 at approximately at 8:00 PM he used the bathroom which caused the brown matter areas on the toilet and wall. Resident #49 revealed Nurse Aide (NA) #5 provided assistance to the bathroom and was aware it needed to be cleaned. Resident #49 explained he was told by NA #5 she would inform housekeeping to clean and sanitize the bathroom. During an interview on 02/28/18 at 10:08 AM, the Housekeeper explained the NA staff were to clean brown matter and the housekeeper would sanitize the area after it was cleaned. The housekeeper revealed the NA staff were in charge of cleaning and sanitizing brown matter when housekeeping staff were not available and NA #5 should have cleaned and sanitized the toilet and wall in room #111. She was unaware room #111 needed to be sanitized during the interview. During an interview on 03/01/18 at 6:22 AM, NA #5 confirmed she had provided toileting assistance to Resident #49 and was aware of the brown matter on the toilet and wall. NA #5 revealed she did not clean the toilet because	F 584	wall beside the toiled and Nurse Aide #5 was aware of brown matter and failed to clean said area. The toilet areas identified were cleaned appropriately at the time of notification of findings. Corrective Action for those having the potential to be affected: All resident toilet areas are potentially at risk. Systematic Changes: DON will educate staff on appropriate cleaning of toilet areas to include location of cleaning supplies for off-shift staff. Monitoring: Rounds will be completed daily Monday through Friday using a round sheet and assigned zone rounds (that include resident toilet areas) with reporting daily Monday through Friday at the morning meeting and/or end of day wrap up meeting with appropriate daily follow-up to identified issues. These rounds will be completed by Department Managers and HS Nurses daily x 4 weeks and weekly x 6 months, with completed audits given to DON. Trends related to rounds will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The administrator will be responsible to ensure any further recommendations are carried out.	

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F 584	Continued From page 7 there were no cleaning/sanitizing supplies available. NA #5 indicated the cleaning supplies available were wash clothes, soap, and water. She revealed the brown matter was dry and harden to the toilet and felt she could not effectively clean/sanitize the area. She explained cleaning/sanitizing supplies were kept locked in a closet when housekeeping staff were not available and they were the only ones who had a key. She indicated the housekeeper had been informed room #111 was a priority to clean and sanitize. During an interview on 03/01/18 at 3:28 PM, the Environmental Services Director (ESD) revealed it was his expectation NA staff cleaned and sanitized brown matter when housekeeping staff were not available. The ESD also revealed NA staff had access to the sanitizing supplies 24 hours a day and the key to the closet hung outside the door at all times.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 636		4/8/18

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(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or

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F 636	Continued From page 9 mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the individual underlying causes, contributing factors and risk factors for 2 of 17 sampled residents. The areas not comprehensively assessed included urinary incontinence care (Resident #112) and nutrition (Resident #51). The findings included: 1. Resident #112 was admitted to the facility on 02/06/18. The admission Minimum Data Set (MDS) dated 02/15/18 indicated Resident #112 had diagnoses which included heart failure, diabetes and a pressure ulcer. The MDS also indicated Resident #112 required extensive assistance with hygiene and toileting. The MDS further indicated Resident #112 had an indwelling catheter. Review of the Care Area Triggers (CAT) for the admission MDS dated 02/15/18 indicated urinary incontinence triggered as an area of concern. The Care Area Assessment (CAA) for the MDS indicated the following information as documented on the CAA: at risk for increased risk for complications including Urinary Tract Infections (UTI's) related to indwelling catheter, no recent labs, diagnosis of diabetes, heart failure, on hospice and stage 3 pressure ulcer on coccyx (the tailbone). The CAA did not indicate an	F 636	F636 Comprehensive Assessment & Timing Corrective Action: It is duly noted that Resident #112's CAA was incorrect in urinary incontinence and Resident #51's CAA was incorrect in the area of nutrition. The Care Area Assessments (CAA) have been corrected for resident #112 in the area of urinary incontinence care and resident #51 in the area of nutrition. Corrective Action for those having the potential to be affected: To determine who else is at risk for uncomprehensive CAAs the MDS staff or Clinical Resource Specialist (CRS) will Review most recent comprehensive MDS for current guests to see who triggered CAAs for urinary incontinence and/or nutrition and determine if CAA is comprehensive. If CAA area found to be uncomprehensive an addendum note will be written in the progress notes. Systematic Changes: The clinical resource specialist (CRS) will provide education to MDS staff on comprehensive care plan and comprehensive care area assessments (CAA). Monitoring: Resident□s MDS with triggered CAA	

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F 636	Continued From page 10 in-depth analysis of all underlying causes, contributing factors, and risk factors for the use of an indwelling catheter. During an interview with the MDS Coordinator (MDSC) on 02/28/18 at 3:24 PM, the MDSC reviewed the CAA for urinary incontinence for Resident #112 and acknowledged the CAA was not comprehensive. During an interview with the Director of Nursing (DON) on 03/02/17 at 6:43 PM, the DON stated her expectations were for the CAA's to be comprehensive. The DON also stated the CAA should tell a story about the resident and you should be able to read the CAA and know all about the resident from the information recorded. 2. Resident #51 was admitted to the facility on 01/08/18. The 5-day Minimum Data Set (MDS) dated 01/16/18 indicated Resident #51 had diagnoses which included diabetes and jaw dislocation. The MDS also indicated Resident #51 required total assistance with nutrition and had a feeding tube. Review of the Care Area Triggers (CAT) for the 5-day MDS dated 01/16/18 indicated nutrition triggered as an area of concern. The Care Area Assessment (CAA) for the MDS indicated the following information: resident was on tube feeding due to dislocation of mandible, triggered due to BMI (Body Mass Index) in the obese range and will refer to Registered Dietician (RD) and Medical Director (MD) as needed. The CAA did not indicate an in-depth analysis of all underlying causes, contributing factors, and risk factors for impaired nutrition.	F 636	areas of urinary incontinence and nutrition will be reviewed weekly X 2 weeks for comprehensive assessment by CRS or designee; then 2 residents MDS□s with triggered CAA areas of urinary incontinence and nutrition will be reviewed weekly X 10 weeks by CRS or designee. Results of this auditing will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The administrator will be responsible to ensure any further recommendations are carried out.	

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F 636	Continued From page 11 During an interview with the MDS Coordinator (MDSC) on 02/28/18 at 5:50 PM, the MDSC reviewed the CAA for nutrition for Resident #51 and acknowledged the CAA was not comprehensive. The MDSC also stated the Dietary Manager that completed the CAA was no longer an employee at the facility. During an interview with the Director of Nursing (DON) on 03/02/17 at 6:43 PM, the DON stated her expectation were for the CAA's to be comprehensive. The DON also stated the CAA should tell a story about the resident and you should be able to read the CAA and know all about the resident from the information recorded.	F 636		
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 reviews and staff interviews the facility failed to correctly code diagnoses on the admission minimum data set assessment (Resident #35), correctly code discharged from the facility on the discharge minimum data set (Resident #60), correctly code restraints were not used on the quarterly minimum data set (Resident #29), and correctly code oxygen was used on the admission minimum data set (Resident #112) for 4 of 21 residents reviewed for accuracy of assessments. Findings included: 1. Resident #35 was admitted to the facility	F 641	F641 Accuracy of Assessments Corrective Action: It is duly noted that all Residents noted below were identified to have inaccurately coded MDS'. Resident #35□s MDS dated 2/4/18 was modified to include diabetes mellitus and thyroid disorder. Resident #60□s MDS dated 1/5/18 was modified to show discharge was to home versus the hospital. Resident #29□s MDS dated 1/23/18 was modified to show that the geri-chair was not a restraint for resident. Resident #112□s MDS dated 2/15/18	4/8/18

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F 641	Continued From page 12 01/08/18 with diagnoses including diabetes and low thyroid hormone. A review of the most recent admission Minimum Data Set (MDS) dated 02/04/18 revealed section I, active diagnoses did not include diabetes mellitus and thyroid disorder. A review of physician's orders revealed levothyroxine (medication for low thyroid) and insulin (medication given for diabetes mellitus) were included during the look back period of the assessment. A review of the Medication Administration Record (MAR) revealed Resident #35 was administered levothyroxine and insulin during the look back period of the assessment. During an interview on 03/02/18 at 3:41 PM, the MDS Coordinator explained she incorrectly coded section I. She confirmed the diagnoses for thyroid disorder and diabetes mellitus was missed and should have been coded on the MDS assessment for Resident #35. During an interview on 03/02/18 at 6:55 PM, the Director of Nursing revealed it was her expectation the MDS Coordinator code assessments and those assessments would be correct. 2. Resident #60 was admitted to the facility 12/20/17 with diagnoses including atrial fibrillation and diabetes mellitus. Resident #60 was discharged to home on 01/05/18. A review of the discharge Minimum Data Set (MDS) dated 01/05/18 revealed section A had	F 641	was modified to show that he had dental issues. Corrective Action for those having the potential to be affected: Newly admitted residents, discharged residents, and residents with devices have the potential to be affected. Newly admitted residents over the last 3 months will have their admission MDS□s reviewed for complete diagnosis and correct coding for dental issues. Discharges over last 3 months will have their discharge MDS□s reviewed for correct coding of discharge place. Residents with devices will have their most recent MDS reviewed for correct coding of restraints. MDS□s found incorrect will be corrected or modified as appropriate. Systematic Changes: Regional clinical resource specialist (CRS) will in-service MDS staff on accuracy of MDS. Monitoring: 5 Admission, Discharge, or Quarterly MDSs will be audited weekly for 4 weeks by CRS or designee and then 5 Admission, Discharge, or Quarterly MDSs will be audited monthly for 6 months by CRS or designee to determine if diagnosis, place of discharge, dental status, and any devices are coded correctly on respective MDS. Results of this auditing will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. If discrepancies noted, action plans will be implemented. The administrator will be responsible to	

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F 641	Continued From page 13	F 641		

been coded to show Resident #60 was discharged to the hospital.

A review of a physician order dated 01/04/18 revealed Resident #60 was being discharged home in the morning if stable.

During an interview on 03/02/18 at 3:48 PM, the MDS Coordinator confirmed Resident #60 was discharged home and the MDS assessment had been incorrectly coded. She stated a modification would be done to reveal Resident #60 was discharged home.

During an interview on 03/02/18 at 6:55 PM, the Director of Nursing revealed it was her expectation the MDS Coordinator code assessments and those assessments would be correct.

3. Resident #29 was readmitted to the facility 01/11/18 with diagnoses which included end stage Parkinson's disease.

A quarterly Minimum Data Set (MDS) dated 01/23/18 indicated Resident #29's cognition was severely impaired. Section P0100 of the MDS was marked to indicate the resident used a restraint daily. "Other" was marked as the type of restraint utilized.

An interview with the MDS Coordinator and the Regional MDS Consultant on 02/28/18 at 2:55 PM revealed the MDS Coordinator stated she marked "Other" in section P0100 in error. The resident used a geri chair daily. The MDS Coordinator explained she thought the resident could not get out of the geri chair therefore making the chair a restraint. The MDS

ensure any further recommendations are carried out.

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Coordinator further explained she had observed the resident attempting to unsafely get out of the chair which indicated the chair was not a restraint. She stated she marked "Other" in section P0100 in error. The Regional MDS Consultant agreed the geri chair was not a restraint for Resident #29.

During an interview with the Director of Nursing (DON) on 03/02/18 at 6:55 PM, the DON stated she expected MDS coding to be correct.

4. Resident #112 was admitted to the facility on 02/06/18. The admission Minimum Data Set (MDS) dated 02/15/18 indicated Resident #112 had diagnoses which included heart failure and diabetes. The MDS also indicated Resident #112 had mild cognitive impairment and required supervision with eating. The MDS further indicated Resident #112 had no dental problems.

Resident #112 was observed on 02/28/18 at 3:09 PM. Resident #112 demonstrated removal of his upper and lower denture plates. Resident #112 stated his teeth were in poor condition so he chose to have them pulled over 20 years ago so he could get dentures.

During an interview on 02/28/18 at 3:24 PM, the MDS Coordinator reviewed the admission MDS assessment dated 02/15/18 indicating Resident #112 had no dental issues. The MDS Coordinator went to observe Resident #112 and visually verified he had a full set of dentures. The MDS Coordinator stated she had not interviewed Resident #112 about his teeth but had gathered the information from the nursing admission assessment which indicated no problems with his teeth.

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F 641	Continued From page 15 During an interview on 03/02/18 at 6:43 PM, the Director of Nursing (DON) stated her expectation was for the MDS coding to be accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		4/8/18

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F 656	Continued From page 16 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to initiate a comprehensive plan of care directing measurable goals and interventions for contractures of fingers and elbow for 1 of 2 residents reviewed for contractures (Resident #31). The findings included: Resident #31 was admitted to the facility 04/25/11 with diagnoses which included history of stroke and left sided weakness and amputations of both legs. An annual Minimum Data Set (MDS) dated 01/14/18 indicated the resident's cognition was intact. The MDS coded the resident required extensive staff assistance for all activities of daily living except eating and had impairment of one side of upper extremities and both lower extremities. A review of Resident #31's medical record revealed a restorative daily program record for the month of February 2018. The daily program identified Resident #31 required active range of motion (AROM) to both lower extremities related to muscle weakness and decreased strength. The goal specified the resident would not incur any loss of AROM by providing active range of motion exercises with 20+ repetitions 1 time a	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective Action: It is duly noted that Resident #31 was identified to have a contracture with no corresponding care plan. A care plan was developed for resident #31 relative to the contracture. Corrective Action for those having the potential to be affected: Other residents with contractures have the potential to be affected. Nursing Administration and therapy will round on residents to identify any residents with contractures. An appropriate care plan will be developed for any resident identified as having contracture(s). Residents are assessed upon admission through the admission nursing assessment for decreased range of motion and contractures. Systematic Changes: Director of Nursing will in-service licensed nurses on the admission nursing assessment and development of interim care plan until comprehensive care plan completed by MDS. Monitoring: Director of Nursing, Assistant Director	

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F 656	Continued From page 17 day for 3-4 days per week to meet objective by May 2018. Interventions included observe for pain, both lower extremity range of motion in all planes 20+ repetitions, and place pillow under 1 lower extremity to prevent further contractures. No mention was made of contractures of the fingers of the resident's left hand and left elbow. A review of the resident's care plans revealed a care plan initiated 02/02/18 which identified Resident #31 with decreased strength and AROM. The care plan goal specified the resident would maintain status and would not incur further loss of range of motion to affected joints. Interventions included allow for rest breaks if resident tires, and bilateral (both) lower extremity range of motion in all planes 20+ repetitions and position left lower extremity with pillow under knee to prevent further contracture. The care plan did not address the resident's left hand and curled fingers for range of motion or interventions that should be utilized to prevent skin breakdown in the resident's left palm and increased contracture in the fingers and the elbow of the resident's left arm. An observation of Resident #31 on 02/28/18 at 10:55 AM revealed the resident was lying in bed. The 3rd, 4th, and 5th fingers of the resident's left hand were observed curled into the palm of that hand. When the resident was asked if the fingers could be straightened, he replied he could not open the fingers on his left hand or straighten out his left arm. The resident did not have a palm protector or rolled bath cloth in the left hand during this observation and interview. An additional observation on 03/01/18 at 1:12 PM revealed Resident #31 had no palm guard or	F 656	of Nursing, and/or Regional Clinical Resource Specialist will utilize a quality assurance monitoring audit to review the care plans of 5 residents with completed comprehensive or quarterly assessments weekly times 4 weeks and then 5 residents with completed comprehensive or quarterly assessments (care plans) monthly for 6 months to ensure care plans are comprehensive. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. If discrepancies found, action plan will be implemented accordingly. The administrator will be responsible to ensure any further recommendations are carried out.	

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F 656	Continued From page 18 rolled bath cloth in his left hand. The 3rd, 4th, and 5th fingers remained curled into the palm of his left hand. During an interview on 03/02/18 at 9:28 AM the MDS Coordinator confirmed Resident #31 did not have a care plan related to contractures of the upper extremities. She further confirmed there were no interventions related to prevention of worsening contracture or the complications these contractures could cause. An interview was conducted with the Corporate MDS consultant (CMDSC) on 03/02/18 at 10:08 AM. The DMDSC agreed the care plan initiated 02/02/18 did not identify Resident #31 with contractors of the fingers of his left hand. She further acknowledged complications of contractures such as skin breakdown caused by contracted fingers curling into the resident's left palm and worsening of these contractures were not addressed in the care plan goal or interventions. An interview was conducted with the Director of Nursing (DON) on 03/02/18 at 7:09 PM. The DON stated her expectation was contractures should be addressed in a care plan with interventions to prevent complications and worsening.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		4/8/18

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F 658	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director (MD) interview the facility failed to follow MD orders to notify the physician of blood sugar levels outside the designated range for 1 of 1 resident reviewed for insulin use (Resident #3). Findings included: Resident #3 was admitted to the facility on 09/08/16 with diagnoses which included diabetes. Record review of the physician's orders for Resident #3 indicated an order for Novolog (insulin) with a start date of 12/13/17 and no end date. The order indicated the following: Novolog insulin injected according to finger stick blood sugars (FSBS obtained by testing a drop of blood) with notification of the MD if the FSBS was 0-69 (low) or 401 (high) or above. FSBS was to be obtained at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM for Resident #3 before administering sliding scale insulin. Record review of the Medication Administration Record (MAR) for February 2018 indicated no documentation the MD had been notified for 16 FSBS readings that were 69 or below ranging from 51 to 69 on the following days: 02/05/18 at 4:30 PM - FSBS of 68 02/06/18 at 4:30 PM - FSBS of 66 02/09/18 at 4:30 PM - FSBS of 63 02/11/18 at 7:30 AM - FSBS of 65 02/11/18 at 4:30 PM - FSBS of 61 02/12/18 at 8:00 PM - FSBS of 51 02/13/18 at 7:30 AM - FSBS of 68 02/15/18 at 4:30 PM - FSBS of 64	F 658	F658 Services Provided Meet Professional Standards Corrective Action: It is duly noted that licensed nurses failed to notify MD of Resident #3's blood sugar levels below 60 in the month of February 2018. Physician was notified of Resident #3□s blood sugar levels on the days in February 2018 that were not documented as notified per parameters. The notification parameters were reviewed with physician and orders were received to notify physician if blood sugar is less than 60 or greater than 450mg/dl. There was no negative outcome to resident. Corrective Action for those having the potential to be affected: Other residents with orders for notification parameters for blood sugar levels are potentially at risk. Notification parameters have been reviewed and orders for notification were reviewed and clarified. No other residents were identified that did not have proper physician notification per physician orders. Systematic Changes: Director of Nursing will educate licensed staff on sliding scale blood sugar checks, parameters for notification and notifying physician when checks indicate levels are outside the ordered acceptable range. Monitoring: Unit managers will audit records of those residents with blood sugar notification parameters weekly for 4	

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F 658	Continued From page 20 02/18/18 at 7:30 AM - FSBS of 64 02/19/18 at 4:30 PM - FSBS of 61 02/20/18 at 4:30 PM - FSBS of 60 02/22/18 at 8:00 PM - FSBS of 69 02/24/18 at 7:30 AM - FSBS of 69 02/24/18 at 4:30 PM - FSBS of 61 02/25/18 at 7:30 AM - FSBS of 63 02/27/18 at 7:30 AM - FSBS of 64 During an interview on 03/01/18 at 9:34 AM the Director of Nursing (DON) and Unit Manager were informed of the missing documentation of the MD being notified of the low FSBS and were asked to assist in locating this information. On 03/01/18 at 9:50 AM, the Unit Manager stated she and the DON had looked and had been unable to find instances where the MD was notified when Resident #3 had FSBS of 69 or lower during February 2018. During an interview by phone with Nurse #1 on 03/01/18 at 10:24 AM, Nurse #1 stated she could not remember if she had contacted the doctor about Resident #3 having a low FSBS of 64 on 02/18/18. Nurse #1 also stated if she had contacted the doctor she would have documented it in nurses' notes. During an interview with Nurse #2 on 03/01/18 at 10:39 AM, Nurse #2 reviewed the MAR for February 2018 and verified Resident #3 had a low FSBS of 63 on 02/09/18 and 68 on 02/13/18. Nurse #2 also stated she could not recall if she had notified the MD on either of these dates, but it would have been in the nurses' notes if she had. During an interview with Nurse #3 on 03/01/18 at	F 658	months and then monthly for 6 months to determine compliance with physician notification of blood glucose parameters. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The administrator will be responsible to ensure any further recommendations are carried out.	

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F 658	Continued From page 21 10:52 AM, Nurse #3 reviewed the MAR for February 2018 and verified Resident #3 had low FSBS on 02/05/18 of 68, 02/06/18 of 66; 02/11/18 of 65; 02/15/18 of 64; 02/19/18 of 61; 02/20/18 of 60; 02/24/18 of 61 and 02/25/18 of 63. Nurse #3 stated she was not aware that the order indicated the MD was to be called for a FSBS of 69 or less. Nurse #3 also stated she had not notified the MD for any of the FSBS that were 69 or less. During a phone interview with Nurse #4 on 03/01/18 at 12:45 PM, Nurse #4 stated she did not remember what the FSBS for Resident #3 had been on 02/27/18 in the AM, but if it was below 69 she should have contacted the MD and made a nurses' note, but she knew she did not do that. During an interview with the MD on 03/02/18 at 10:54 AM, the MD reviewed the February 2018 MAR for Resident #3. The MD stated that he had not been made aware when Resident #3 had low FSBS and if he had been made aware he would have adjusted her insulin. The MD also stated Resident #3 had no signs of hypoglycemic episodes that he had been made aware of and that no harm had occurred. During an interview with the DON on 03/02/18 at 6:43 PM, the DON stated her expectations were for the nurses to be following the MD orders.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		4/8/18

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F 684	Continued From page 22 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, resident, and physician interviews the facility failed to provide measures to prevent complications related to contracted fingers for 1 of 2 residents reviewed for contractures (Resident #31) and to assess and monitor wounds and skin condition between wound clinic evaluations for 1 of 1 resident observed for vascular wounds (Resident #27). The findings included: 1. Resident #31 was admitted to the facility 04/25/11 with diagnoses which included history of stroke and left sided weakness and amputations of both legs. An annual Minimum Data Set (MDS) dated 01/014/18 indicated the resident's cognition was intact. The MDS coded the resident required extensive staff assistance for all activities of daily living except eating and had impairment of one side of upper extremities and both lower extremities. The MDS further coded the resident with no rejection of care exhibited. A review of Resident #31's care plans revealed no plan of care was provided to treat and prevent complications of contracted fingers and elbow of the resident's left upper extremity. A review of a Nursing Care Card dated 12/14/16 and used by the nurse aides (NA) to provide care for Resident #31 revealed no instructions for a	F 684	F684 Quality of Care Corrective Action: It is duly noted that Resident #31 had contracture with no restorative plan in place to prevent further decline. Resident #31 was evaluated by therapy and is receiving therapy services for treatment of contracture. It is duly noted that Resident #27 had 2 skin assessments with conflicting information and no measurements of said areas. Resident #27□s skin assessment was completed on resident'□s vascular wounds. Corrective Action for those having the potential to be affected: Other residents with contractures have the potential to be affected. Nursing Administration and therapy will round on residents to identify any residents with contractures. An appropriate treatment plan will be developed for any resident identified as having contracture(s). Residents are assessed upon admission through the admission nursing assessment for decreased range of motion and contractures. Newly identified residents will be evaluated for appropriate treatment plan. Other residents with skin issues are potentially at risk. A 100% skin assessment was completed to identify any	

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F 684	Continued From page 23 palm protector for the resident's left hand. An observation of Resident #31 on 02/28/18 at 10:55 AM revealed the resident was lying in bed. The 3rd, 4th, and 5th fingers of the resident's left hand were observed curled into the palm of that hand. The fingertips of the contracted fingers could not be observed. When the resident was asked if the fingers could be straightened, he replied he could not open the fingers on his left hand or straighten out his left arm. The resident stated a staff person came to work with his left arm, hand, and legs every few days. The resident did not have any palm protector in the left hand during this observation and interview. An additional observation on 03/01/18 at 1:12 PM revealed Resident #31 lying in bed with the 3rd, 4th, and 5th, fingers of his left hand curled into the palm of that hand. No palm protector was in place to prevent the resident's finger nails from causing skin breakdown and to keep the fingers from further contraction. An interview with the Restorative NA (RNA) on 03/01/18 at 2:34 PM revealed she provided active range of motion for Resident #31's lower extremities and left arm and hand 3 days per week. She confirmed the resident's fingers of the left hand were contracted and curled into the palm of that hand. The RNA stated with help the resident could barely open the fingers on his left hand. She added he should have a rolled bath cloth in his hand for his fingers to wrap around. The RNA stated she does not recall the last time she observed any kind of palm protector or bath cloth roll in Resident #31's left hand. During an interview on 03/01/18 at 4:02 PM the	F 684	other residents that may not have weekly skin assessment. Individual skin or pressure ulcer sheets will be initiated for any identified areas. Systematic Changes: Director of Nursing will in-service licensed nurses on the referring residents with contractures to therapy for development of appropriate treatment plan. Licensed staff will also be in-serviced on completion of weekly skin assessments as well as use of individual skin or pressure ulcer sheets to document measurements and skin characteristics. Monitoring: Director of Nursing or designee will utilize a quality assurance monitoring audit to review current residents or newly admitted residents with contractures weekly times 4 weeks and then monthly for 2 months to ensure that they have appropriate treatment. Director of Nursing or designee will also use a quality assurance monitoring tool weekly for 4 weeks and then monthly for 2 months to ensure that wounds listed on pressure ulcer and skin condition logs have corresponding individual pressure ulcer and skin condition sheets that document measurements and wound characteristics. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. Any discrepancies found will result in implementation of appropriate action plan. The Administrator will be responsible for any follow-up on any recommendation from	

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F 684	Continued From page 24 Director of Nursing (DON) confirmed there were no instructions on the Nurse Care Card for NAs to place a rolled bath cloth in the resident's left hand. The DON stated the resident should have a palm protector in his hand. An interview was conducted with the MDS Regional Consultant (MDSRC) on 03/02/18 at 9:43 AM. The MDSRC confirmed no interventions were in place for a rolled bath cloth to be placed in Resident #31's left hand. The MDSRC further acknowledged a rolled bath cloth would prevent fingernails from the contracted fingers from causing skin breakdown in the palm of the left hand. On 03/02/18 at 3:30 PM Resident #31 was observed with a rolled bath cloth in his left hand. The fingernails of the contracted fingers were observed clean and trimmed. No palm odor was noted during this observation. The resident explained the rolled cloth would keep his fingers from becoming more contracted. He refused to let Nurse #2 remove the cloth in an attempt to observe Resident #31's left palm. The resident explained to Nurse #2 his fingers were too sore and hurt when they were moved and refused for his left hand to be examined. 2. Resident #27 was readmitted to the facility 03/10/16 with diagnoses which included venous ulcers of ankles and multiple sclerosis. A care area assessment (CAA) associated with an annual Minimum Data Set (MDS) dated 03/14/17 specified Resident #27 had chronic venous ulcers to his right and left ankles. The CAA further specified treatments were in place for both areas. The CAA continued the resident was	F 684	the committee and additional training as indicated.	

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F 684	Continued From page 25	F 684		

followed by wound care out of the facility and was at risk for infection and additional skin breakdown due to required staff assistance for bed mobility and transfers.

A care plan dated 03/27/17 described Resident #27 with actual impaired skin integrity related to venous stasis ulcer to the right ankle. The care plan goal specified the area of skin breakdown will be free of signs and symptoms of infection through the next review. Interventions included measure area weekly and document its characteristics in the skin log and conduct weekly head to toe skin assessments and report abnormal findings to physician and chart in nurses' notes.

A care plan dated 06/18/17 described actual impaired skin integrity related to a venous ulcer to the left ankle. The care plan goal specified the skin area would be free of signs and symptoms of infection through the next review period. Interventions included measure area weekly and document its characteristic in the skin record and observe for signs of infection and report to the physician.

A quarterly MDS dated 01/19/18 indicated Resident #27's cognition was moderately impaired. The MDS coded the resident required extensive staff assistance with transfers, bed mobility, dressing, toileting, and personal hygiene. The MDS noted the resident had 2 venous/arterial ulcers at the time of this assessment.

A review of Resident #27's medical record revealed physician orders 10/17/17, 11/07/17, 11/21/17, 12/05/17, 12/20/17, and 02/06/18 from

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F 684	Continued From page 26	F 684		

the wound clinic Resident #27 attended. The orders contained measurements of the right and left ankle wounds, orders for treatments for these areas and the time to return to the wound clinic. The orders for the resident's next wound clinic appointments specified to return to the wound clinic in 2 or 3 weeks and as needed. The orders did not provide assessments of surrounding tissues or the condition/appearance of the resident's feet or circulatory status. The facility was unable to provide further documentation from the wound care clinic.

Further medical record review revealed no documentation regarding nursing assessments of the ankle wounds between visits to the wound clinic. Review of skin assessments completed 02/08/18, 02/22/18, 03/01/18 by Nurse #6 contained no description of the resident's ankle wound nor the skin surrounding them. Review of nurses' notes revealed no documentation of wound assessments between wound clinic visit or condition of surrounding skin. Nurse #6 was unavailable for interview.

An observation on 03/01/17 at 1:12 PM was conducted of Nurse #2 providing a dressing change to Resident #27's ankles. The nurse followed the orders provided by the wound clinic physician. During the dressing change, a dark bluish colored area was observed on the side of Resident #27's left great toe. On the resident's right foot, the great toe and the next 3 toes were observed dark blue in color. The tops of both feet were observed dark red in color. Nurse #2 stated she did not provide wound care for Resident #27 on a regular basis and could not provide a baseline for condition of the resident's feet.

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F 684	Continued From page 27 An interview with the Medical Director (MD) on 03/02/18 at 11:22 AM revealed he had examined Resident #27's feet on this date and stated they appeared unchanged from the past. He added the resident's ankle wounds were vascular in nature and he was aware of the resident's vascular disease. The MD added the ankle wounds were improving. During an interview on 03/02/18 at 2:29 PM the Director of Nursing (DON) provided documentation of physician orders from the wound care clinic that specified appointments were every 2 to 3 weeks depending on the wound care visit request sent to the facility following each wound care appointment. The DON was unable to provide facility assessments between wound care visits. She stated weekly skin assessments should include the fact the resident had wounds on his ankles and describe discoloration of the lower extremities and toes to provide a baseline so complications could be recognized.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to	F 689	F689 QOC Free of Accident Hazards/Supervision/Devices	4/8/18

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F 689	Continued From page 28 provide supervision to promote safe smoking for 1 of 1 resident reviewed for smoking (Resident #46). The findings included: A review of the facility's smoking policy revised 06/17 and titled Guest Smoking included the purpose of this policy was to provide and maintain guest smoking practices to ensure the safety and comfort of all guests, staff, and visitors. Smoking materials must be brought to the nurse's station to be secured and were labeled with the guest's name and used exclusively for that individual. Resident #46 was admitted to the facility 11/01/17 and readmitted 01/04/18 with diagnoses which included diabetes mellitus and tobacco use. The readmission of 01/04/18 also included a diagnosis of post toe amputations. A copy of a smoking policy titled Guest Smoking was provided by the facility. The smoking policy was signed by Resident #46 and dated 11/02/17. A signature of the Admissions Coordinator was also present on the smoking policy as indicated by signature dated 11/02/17. No copy of a smoking policy was provided for the 01/04/18 readmission for Resident #46. An admission Minimum Data Set (MDS) dated 01/11/18 indicated Resident #46's cognition was intact. The MDS coded the resident with clear speech, understands others, could be understood by others, and required extensive assist for personal care and supervision for locomotion. Tobacco use was marked no. A review of Resident #46's medical record revealed an unsigned nurse admission form	F 689	Corrective Action: It is duly noted that Resident #46 had smoking paraphernalia in his room and was not aware that it was to be locked up in med cart according to policy. Resident #46 was educated on the smoking policy, the policy was reviewed by resident and signed and smoking assessment was completed X 3 per policy. Resident was assessed and remained independent with cigarette smoking. Care plan revised and includes interventions related to smoking. Corrective Action for those having the potential to be affected: Other residents that smoke have the potential to be affected. The smoking assessments were completed on these residents per policy. The smoking policy was revised. The revised policy was reviewed and signed by the current smoking residents. Nursing will evaluate new admissions through the admission nursing assessment as a resident that wants to smoke and will complete the assessments per policy. A copy of the policy will be reviewed and signed and given to newly admitted residents through the admission office at sign-in. Systematic Changes: DON will educate Facility staff on the revised smoking policy that will include resident smoking supervision and safety issues related to oxygen use. In addition, resident smoking will be reviewed during facility orientation to include that residents will not keep smoking paraphernalia in	

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F 689	Continued From page 29	F 689		

dated 01/06/18. This form did not contain any information regarding smoking. Continued review of Resident #46's medical record revealed a smoking assessment dated 02/27/18 which designated the resident was a safe smoker. A review of the resident's care plans revealed no care plan for smoking.
An observation on 02/28/18 at 4:19 PM revealed Resident #46 was sitting in his wheelchair in his room. A pack of cigarettes was observed in his shirt pocket with 1 cigarette visible.

An interview with the MDS Coordinator on 03/01/18 at 4: 19 PM revealed the resident was not reported to her as smoking when he was readmitted to the facility on 01/04/18.

An interview with Resident #46 on 03/02/18 revealed he was smoking when he reentered the facility on 01/04/18. He stated to the best of his recollection, someone did ask him if he smoked but was unable to recall who asked that question. Resident #46 stated he always had his cigarettes with him and kept his lighter in his room. He explained he just recently found out he was not supposed to keep his cigarettes with him. Resident #46 added he did not tell anyone he had cigarettes in his room because no one explained the smoking rules to him until just recently.

An interview with Nurse #7 and Nurse #8 was conducted 03/02/18 at 7:36 AM. Both nurses stated they always worked on the hall where Resident #46 resided. Both nurses were hired within the past 7 months. Neither nurse got any orientation regarding the smoking policy for residents when they started working for the facility. Both nurses stated they had knowledge of Resident #46 keeping his cigarettes and lighter in

room or on Being even though they may have been assessed as independent with smoking. This training will also include safety issues related to Oxygen use.

Monitoring:
All newly admitted residents will have his/her business office file audited by Administrator on an ongoing basis to ensure a copy of the smoking policy has been received and reviewed with the resident upon admission. In addition, identified smoking residents will be audited with quarterly, annual or significant change assessment by MDS Coordinator on an ongoing basis to ensure that smoking assessments are updated and care plan in place. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator will be responsible for any follow-up on any recommendation from the QA Committee and additional training as indicated.

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F 689	Continued From page 30 his room but thought it was alright to do this since the resident was alert and oriented. Nurse #8 stated she learned through relief nurses that Resident #46 was cognitively alert to safely smoke and had no idea he was not supposed to keep his cigarettes in his room. An interview with the Admissions Coordinator (AC) was conducted 03/02/18 at 8:05 AM. The AC explained the facility's smoking rules were located in the admission handbook. The resident/responsible party signed they received the handbook. The AC stated if the resident reported to her they were a smoker, she would inform either the Director of Nursing (DON) or the Assistant Director of Nursing. The AC stated she replaced the AC that was working for the facility when Resident #46 was readmitted in January. An interview was conducted 03/02/18 at 11:24 AM with the Regional Manager (RM). At this time, the RM provided a copy of the smoking policy signed by Resident #46 on 11/01/17. The RM stated another smoking policy should have been provided to Resident #46 when readmitted 01/04/18. An interview was conducted with the DON on 03/02/18 at 7:03 PM. The DON stated her expectation was for smoking assessments to be done upon admission for smokers. The DON added she expected nurses to be oriented regarding smoking rules for residents. She added another smoking policy should have been signed when Resident #46 was readmitted to the facility on 01/04/18.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		4/8/18

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F 690	Continued From page 31 §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 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 observations, record review, and staff interviews, the facility failed to prevent a urinary	F 690	F690 □ Bowel/Bladder Incontinence, Catheter, UTI	

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F 690	Continued From page 32 drainage bag and tubing from touching the floor for 1 of 2 residents reviewed for urinary catheters (Resident #27). The findings included: Resident #27 was readmitted to the facility 03/10/16 with diagnoses which included multiple sclerosis and neurogenic bladder. A care area assessment (CAA) associated with an annual Minimum Data Set (MDS) dated 03/14/17 specified Resident #27 had a diagnosis of multiple sclerosis and a neurogenic bladder (dysfunction of nerves that cause inability to pass urine without use of a catheter). The resident was at risk for UTIs and injury related to suprapubic catheter (a urinary catheter placed through the lower abdomen directly into the urinary bladder) use. A care plan dated 03/27/17 identified Resident #27 at risk for urinary tract infections (UTI) due to a history of UTI and the need for a suprapubic urinary catheter related to urinary retention. The care plan goal specified the resident would be free from signs and symptoms of UTI through the next 90 day review period. Interventions included provide catheter care per protocol and change catheter per physician's orders. A review of Resident #27's medical record revealed the resident's last UTI was diagnosed and treated 01/03/18. A quarterly MDS dated 01/19/18 indicated Resident #27's cognition was moderately impaired. The MDS coded the resident required extensive staff assistance for bed mobility, transfers, dressing, toileting and personal hygiene	F 690	Corrective Action: It is duly noted that Resident #27's foley catheter bag was not positioned in a way that kept it from touching the floor. Resident #27□'s Foley catheter drainage bag and tubing was repositioned so that is was not touching the floor. Corrective Action for those having the potential to be affected: Other residents with Foley drainage bags and tubing are potentially at risk. Rounds were completed to ensure that Foley drainage bags and tubing were positioned correctly so that they were not touching the floor. No other residents were identified. Systematic Changes: Licensed staff and certified nursing assistants will be in-serviced by DON on appropriate positioning and monitoring of Foley drainage bags and tubing. Monitoring: Unit managers will make 5 observation audits weekly for 4 weeks of Foley drainage bag and tubing placement and then 5 observation audits monthly for 2 months. Results of these audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The DON will be responsible for any follow-up on any recommendations from the QA Committee and additional training as indicated.	

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F 690	Continued From page 33	F 690		

and staff supervision with locomotion on and off the unit. The MDS specified the resident had an indwelling urinary catheter and used a wheelchair for locomotion.

An observation on 02/28/18 at 8:06 AM revealed Resident #27 was self-propelling down the hall in his wheelchair. A covered urinary drainage bag was hanging under his wheelchair seat and was dragging the floor. Nurse Aide (NA) #1 approached the resident to change a clothing protector but did not reposition the dragging catheter bag.

An additional observation on 02/28/18 at 9:43 AM revealed the resident was sitting in his wheelchair in his room watching television. The urinary catheter bag was hanging under his wheelchair seat and was touching the floor. The drainage bag tubing was lying on the floor between the resident's feet.

Further observation on 02/28/18 at 4:40 PM revealed Resident #27 was self-propelling his wheelchair from the facility's living room down the hallway to his room with the catheter drainage bag was hanging under the resident's wheelchair seat and was dragging the floor. The drainage bag tubing was, also, dragging the floor.

An interview was conducted 02/28/18 at 5:04 PM with NA #2 who was assigned to Resident #27 for the 7 AM to 7 PM shift on this date. NA #2 acknowledged Resident #27's urinary catheter bag was dragging the floor. The NA stated the bag would not fit any other way under the wheelchair seat. After working with the bag, NA #2 found a way to attach the bag under the wheelchair seat so the bag and tubing were not

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F 690	Continued From page 34 dragging the floor and the bag remained under the wheelchair seat. An interview with the Director of Nursing (DON) on 02/28/18 at 5:48 PM revealed her expectation was for urinary catheter bags be attached under wheelchair seats so that the drainage bag and tubing were not dragging the floor. The DON stated this was an infection control issue. An observation on 03/01/18 at 6:15 AM revealed Resident #27 was sitting in his wheelchair in his room watching television. The urinary catheter bag hanging from under the resident's wheelchair seat was partially lying on the floor. During an interview at this time, NA #3 recognized the problem. The NA stated the bag must have slipped. NA #3 repositioned the drainage bag under the wheelchair seat so it would not drag on the floor.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		4/8/18

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F 756	Continued From page 35 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Pharmacy Consultant interviews, the facility failed to ensure a monthly Medication Management Review (MMR) was completed for 1 of 6 residents reviewed for unnecessary medication (Resident #35). Findings included: A review of the pharmacy services contract read in part: consultant services once each month, consult with facility's staff as to each residents' drug regimen and provide a written report of concerns of inappropriate utilizations patterns (if any) to the facility's Administrator, DON or the	F 756	F756 □ Drug Regimen Review, Report irregular, Act on Corrective Action: Resident #35 did not have a February Monthly Medication Review (MMR) completed. There was no negative outcome to resident. Corrective Action for those having the potential to be affected: All residents who are out to the hospital when MMR□s are completed are potentially affected. DON/designee will audit the last 3 months of MMR summaries to see if there were any other residents out to the hospital when reviews	

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F 756	Continued From page 36 physician, as appropriate. Resident #35 was admitted to the facility 01/08/18 with diagnoses including atrial fibrillation, chronic obstruction pulmonary disease (COPD), and diabetes. A review of physician progress notes dated 01/10/18 revealed the resident was recently admitted from hospital and had a high risk for morbidity and re-hospitalization. A review of the admission Minimum Data Set (MDS) dated 02/04/18 indicated Resident #35 was cognitively intact with no rejection of care or behaviors. She had received insulin, antidepressant, anticoagulant, diuretic, opioid, and oxygen during the assessment period. A review of the care plan initiated 02/08/18 identified problems of fluctuating blood sugars and risk for bleeding due to coumadin use (a blood thinner medication). Review of a nurse note dated 02/13/18 at 7:35 AM, revealed Resident #35 was transferred to emergency room for evaluation of chest pain. Review of a physician order dated 02/13/18 directed staff to send Resident #35 to the emergency room for evaluation of chest pain. A review of the February Medication Administration Record (MAR) revealed nurses initialed Resident #35 was absent from the facility on 02/13/18 and did not receive medications at 8:00 AM and 9:00 AM. The documentation also revealed medications were received on 02/13/18 at 4:00 PM and continued from there through	F 756	were completed. Systematic Changes: The pharmacy manager will in-service the consulting pharmacist on the expectation that reviews be completed on all residents in-house and to apprise the DON of any resident that review could not be completed on due to being out at the hospital. If the resident returns the same month but after the MMRs are completed the DON will coordinate with the consulting pharmacist getting the MMR completed. Monitoring: DON will review MMR summaries monthly for 3 months to see if there are any residents at hospital on day of MMR and will coordinate getting MMR done with consulting pharmacist in the event that the resident returns the same month but after the MMRs were completed for month. Continued compliance will be maintained through monthly review of MMR summaries. The DON will take results of reviews to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator will be responsible for any follow up on any recommendation from he QA Committee and additional training as indicated.	

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F 756	Continued From page 37	F 756		

02/28/18 indicating the resident had returned to the facility. Medications changes occurred for Resident #35 on 02/13/18, 02/19/18, 02/20/18, and 02/22/18.

A review of the monthly MMR revealed the Pharmacy Consultant had not reviewed the medications for Resident #35 for February. The Pharmacy Consultant made a notation the patient was hospitalized.

During an interview on 03/02/18, the Pharmacy Consultant explained on 02/13/18 he was at the facility for the MMR and Resident #35 was not reviewed due to being sent to the hospital. The Pharmacy Consultant further explained when a resident was discharged from the hospital a summary of their medications would be faxed to the pharmacy and the pharmacist would review the medications at that time. The Pharmacy Consultant explained medications can change when residents were sent to the hospital and he reviewed their current medications the day of the MMR. It was his understanding the MMR was done for residents in the facility on the day of the MMR and he would not be expected to provide the MMR when residents were not physically in the facility the day of his review. He thought the resident was admitted and was not aware she had returned the same day of the MMR.

During an interview on 03/02/18 at 1:30 PM, the Regional Quality Assurance Manager explained when a resident was sent to the hospital and the pharmacy review was missed we would not expect the Pharmacy Consultant to return for the MRR. When a resident was sent to the hospital they typically have medications changes and those were reviewed by the Medical Doctor at the

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F 756	Continued From page 38 hospital and the facility Medical Doctor or Nurse Practitioner. She was aware the contract for pharmacy services was for a monthly medical review. It was her understanding the MMR was done for residents present in the facility at the time of the review. She explained if a resident was not admitted to the hospital and returned to the facility on the same day or the next day they would not expect the pharmacy consultant to provide the MMR.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure hamburger and hot dog buns had a use by date when removed from the freezer, buns with visible blue/green areas were	F 812	F812 □ Food Procurement; Store/Prepare/Serve-Sanitary Corrective Action: Dietary Aide failed to date buns that	4/8/18

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F 812	Continued From page 39 thrown away, and bread with expired dates were not stored on the same cart with unexpired bread ready to be served to residents. Findings included: During an observation on 02/27/18 at 8:35 AM, the top rack of the bread cart located beside the serving line revealed packages of opened hamburger buns with a use by date of 12/20/17. Another package of hamburger buns with a use by date 01/14/18 with 1 bun revealing a discolored blue/green, quarter size area. An unopened package of hot dog buns with the use by date 01/16/18, an unopened package of hamburger buns with a use by date 1/24/18. Two opened packages of wheat bread with the use by date 02/08/18 and 02/22/18. The expired packages of bread including the bun with blue/green areas were being stored on the top rack of the bread cart beside the serving line in the main kitchen with several racks of unexpired bread ready to serve. During an interview on 02/27/18 at 8:43 AM, the Dietary Manager revealed hotdog and hamburger buns were kept in the freezer and removed as needed. He also revealed the buns should be dated when taken from the freezer and used by 3 days, or thrown away. He confirmed there were no dates to identify when the buns were removed from the freezer. He also identified the blue/green area on a hamburger bun in one of the expired packages. His expectations were for the kitchen staff to write the date buns were removed from the freezer and to throw them away after 3 days if not used. He also expected bread with green/blue areas would be thrown away and expired bread would not be stored on the same bread cart with	F 812	were pulled from the freezer resulting in risk of serving expired items. The hot dog and hamburger buns were discarded on the day they were discovered. The expired bread was also discarded on the day they were discovered. Corrective Action for those having the potential to be affected: The dietary manager inspected all other food storage areas in the facility and found no other outdated items. Systematic Changes: All dietary department employees will be re-educated by Dietary Manager on food labeling and storage to include writing dates when bread items pulled from the freezer and discarding these items if not used within 3 days/72 hours as well as not storing outdated bread type items on the bread rack with unexpired bread items ready to be served. Monitoring: The dietary manager will conduct rounds/audits daily for 4 weeks Monday □ Friday; then weekly for 2 months to determine if there are any outdated items in food storage areas. The dietary manager will take results of rounds/audits to QA and review monthly at the Quality Assurance Committee Meeting for any further recommendations. The administrator will do weekly audits for 2 months and monthly audits for 6 months thereafter and report findings to monthly QA meeting. Deficiency will be reviewed and discussed at monthly QA meetings x	

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F 812	Continued From page 40 unexpired bread ready to serve. During an interview on 03/02/18 at 7:53 PM, the Administrator revealed his expectations were for the kitchen staff to write the date buns were removed from the freezer and to be used within 72 hours/3 days. His expectations were for bread with blue/green spots to be thrown away, expired bread to be thrown away, and not stored with unexpired breads ready to serve.	F 812	1 year and any new discrepancies will be addressed with action plan. The Administrator will be responsible for any follow up on any recommendation from the QA Committee and additional training as indicated.	
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include information in the facility's smoking policy provided to residents upon admission regarding safety issues of oxygen use while smoking. The findings included: A review of the facility's smoking policy titled Guest Smoking revised 06/17 revealed the policy included rights of unsupervised and supervised smokers and where residents were allowed to smoke and not smoke. The policy provided instruction that smoking materials were to be kept by the nurse in a secured area on the unit. The policy did not address smoking safety and the use of oxygen while smoking.	F 835	F835 Administration Corrective Action: The smoking policy was reviewed and did not include safety issues of oxygen use while smoking. Corporate QA staff notified and alerted to need for policy revision. Corrective Action for those having the potential to be affected: All residents and staff educated on the smoking policy have the potential to be affected by policy not addressing safety issues of oxygen use while smoking. Systemic Changes The smoking policy has been updated to address safety issues of oxygen use	4/8/18

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F 835	Continued From page 41 An interview was conducted with the Administrator and Regional Manager on 03/02/18 at 6:43 PM. Both agreed the facility's smoking policy did not address the use of oxygen while smoking.	F 835	while smoking. Signs were place in smoking area advising that oxygen should not be worn in that area. Current residents or RPs will receive a copy of the revised smoking policy. Facility staff will be in-serviced by DON on the revised smoking policy that will include resident smoking supervision and safety issues related to oxygen use. In addition, resident smoking will be reviewed during facility orientation to include that residents will not keep smoking paraphernalia in room or on Being even though they may have been assessed as independent with smoking. This training will also include safety issues related to Oxygen use. Monitoring: Round audits by Environmental Services Director or designee will be completed 5 times a week for 4 weeks; then 1 time per week for 2 months to determine if oxygen signs remain posted and that there are no identified safety concerns related to resident smoking. Results of the audits will be taken to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator will be responsible for any follow-up on any recommendation from the QA Committee and additional training as indicated.	
F 867 SS=E	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	F 867		4/8/18

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F 867	Continued From page 42 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: The facility Quality and Assurance Committee failed to maintain procedures and monitor interventions the committee put in place following the recertification/complaint survey of 02/17/17. The deficiencies were originally cited on 02/17/17 and subsequently recited during the current recertification and complaint survey of 03/08/18. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: These tags cross-referenced to: 1. a. 483.10 (g)(14)(i)-(iv): Notify of Changes (Injury/Decline/Room, Etc.): Based on record review, staff and Medical Director (MD) interview the facility failed to notify the MD of blood sugar levels outside the ordered range acceptable for Resident #3. This was evident in 1 of 1 resident reviewed for notification of MD. The facility was recited F 580 for failing to notify changes in blood sugar levels as requested by the physician. F 580 was originally cited during the recertification and complaint survey of 02/17/17 for failure to notify the physician, Director of Nursing, and the Responsible Party of a medication error: causing a change in condition, nausea and vomiting, a decreased in blood pressure and pulse.	F 867	F867 QAPI/QAA Improvement Activities Corrective Action: Physician was notified of Resident #3□s blood sugar levels on the days in February 2018 that were not documented as notified per parameters. The notification parameters were reviewed with physician and orders were received to notify physician if blood sugar is less than 60 or greater than 450mg/dl. There was no negative outcome to resident. The toilet areas identified were cleaned appropriately at the time of notification of findings. The Care Area Assessments (CAA) have been corrected for resident #112 in the area of urinary incontinence care and resident #51 in the area of nutrition. Resident #35□s MDS dated 2/4/18 was modified to include diabetes mellitus and thyroid disorder. Resident #60□s MDS dated 1/5/18 was modified to show discharge was to home versus the hospital. Resident #29□s MDS dated 1/23/18 was modified to show that the geri-chair was not a restraint for resident. Resident #112□s MDS dated 2/15/18 was modified to show that he had dental issues. Physician was notified of Resident #3□s blood sugar levels on the days in February 2018 that were not documented as notified per parameters. The notification parameters were reviewed with physician	

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F 867	Continued From page 43 b. 483.10 (i)(1)-(7): Safe/Clean/Comfortable/Homelike Environment: Based on observations, resident, and staff interviews the facility failed to clean/sanitize a toilet with a moderate amount of brown matter on the back of a toilet lid, the toilet seat, and the wall beside the toilet for 1 of 13 bathrooms reviewed for a safe/clean/comfortable/homelike environment (Room #111). The facility was recited F 584 for failing to clean/sanitize a bathroom including a soiled toilet and wall. F 584 was originally cited during the recertification and complaint survey of 02/17/17 for failure to keep walls clean in resident rooms and keep bathroom floors clean and free from stains around the base of commodes. c. 483.20 (b)(1)(2)(i)(iii): Comprehensive Assessment and Timing: Based on medical record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the individual underlying causes, contributing factors and risk factors for 2 of 17 sampled residents. The areas not comprehensively assessed included urinary incontinence care (Resident #112) and nutrition (Resident #51). The facility was recited F 636 for failing to complete a Care Area Assessment of underlying causes, contributing, and risk factors for impaired nutrition and urinary incontinence. F 636 was originally cited during the recertification and complaint survey of 02/17/17 for failure to complete a Care Area Assessment that addressed the underlying causes and contributing factors for psychotropic drug use and nutrition.	F 867	and orders were received to notify physician if blood sugar is less than 60 or greater than 450mg/dl. There was no negative outcome to resident. Resident #31 was evaluated by therapy and is receiving therapy services for treatment of contracture. Resident #27□s skin assessment was completed on resident□s vascular wounds. The hot dog and hamburger buns were discarded on the day they were discovered. The expired bread was also discarded on the day they were discovered. Nurse #7 who did not wear gloves during blood sugar finger stick and same nurse who did not disinfect glucometer during use was removed from the cart. She is no longer employed by facility. Nurse Aide #1 received 1:1 education regarding not placing oxygen tubing back on resident if the tubing has touched the floor. Corrective Action for those having the potential to be affected: Other residents with orders for notification parameters for blood sugar levels are potentially at risk. Notification parameters have been reviewed and orders for notification were reviewed and clarified. No other residents were identified that did not have proper physician notification per physician orders. All resident toilet areas are potentially at risk. To determine who else is at risk for uncomprehensive CAAs the MDS staff will Review most recent comprehensive MDS	

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F 867	Continued From page 44 d. 483.20 (g): Accuracy of Assessment: Based on record reviews and staff interviews the facility failed to correctly code diagnoses on the admission minimum data set assessment (Resident #35), correctly code discharged from the facility on the discharge minimum data set (Resident #60), correctly code restraints were not used on the quarterly minimum data set (Resident #29), and correctly code having no teeth on the admission minimum data set (Resident #112) for 4 of 21 residents reviewed for accuracy of assessments. The facility was recited F 641 for failing to accurately code assessments for diagnoses, discharge, restraints, and having no teeth. F 641 was originally cited during the recertification and complaint survey of 02/17/17 for failure to accurately code assessments to reflect a resident was identified as Level II on the Preadmission Screening and Resident Review. e. 483.21(b)(3)(i): Services Provided Meet Professional Standards: Based on record review, staff and a Medical Director (MD) interview the facility failed to follow MD orders and notification of blood sugar levels outside the designated range for 1 of 1 resident reviewed for insulin use (Resident #3). The facility was recited F 658 for failing to follow physician orders for notification of high and low blood sugar levels. F 658 was originally cited during the recertification and complaint survey of 02/17/17 for failure to follow physician's orders and take weights as ordered. f. 483.25: Quality of Care: Based on	F 867	for current guests to see who triggered CAAs for urinary incontinence and/or nutrition and determine if CAA is comprehensive. If CAA area found to be uncomprehensive an addendum note will be written in the progress notes. Newly admitted residents, discharged residents, and residents with devices have the potential to be affected. Other residents with contractures and other residents with skin issues are potentially at risk. Other food storage areas are potentially at risk. Other residents who receive blood glucose finger sticks are potentially at risk if gloves are not worn or glucometer is not disinfected. Other residents who wear oxygen are potentially at risk for infection control issues related to oxygen use. Systematic Changes: The QAPI committee will be in-serviced by the Regional QA Nurse by 4/4/18, on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education includes determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. Monitoring: Results of the identified monitoring activity under the tags will be reported by the DON to the monthly QAPI/QA meeting	

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	345438	A. BUILDING _____ B. WING _____	C 03/08/2018

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F 867	Continued From page 45 observations, record review, staff, resident, and physician interviews the facility failed to provide measures to prevent complications related to contracted fingers for 1 of 2 residents reviewed for contractures (Resident #31) and to assess and monitor wounds and skin condition between wound clinic evaluations for 1 of 1 resident observed for vascular wounds (Resident #27). The facility was recited F 684 for failing to implement care preventing contracture complications and assess and monitor wounds. F 684 was originally cited during the recertification and complaint survey of 02/17/17 for failure to monitor, assess for and recognized a change in condition following a significant medication error. g. 483.60 (i)(1)(2): Food Procurement, Store/Prepare/Serve-Sanitary: Based on observations and staff interviews the facility failed to ensure hamburger and hot dog buns had a use by date when removed from the freezer, buns with visible blue/green areas were thrown away, and bread with expired dates were not stored on the same cart with unexpired bread ready to be served to residents. The facility was recited F 812 for not discarding expired and discolored food and not labeling food with a use by date. F 812 was originally cited during the recertification and complaint survey of 02/17/17 for failure to ensure expired fruit, milk, undated beverages were discarded. h. 483.80 (a)(1)(2)(4)(e)(f): Infection Prevention and Control: Based on record review, observations, physician, and staff interviews the facility failed to disinfect a glucometer (a medical device used to determine the approximate	F 867	for any further recommendations or root cause analysis. The DON will be responsible for any follow-up on any recommendation from the committee and additional training as indicated. The Regional QA Nurse will review each month's QAPI/QA meeting minutes and make recommendations as needed. Any recommendations will be followed up with appropriate action plan.	

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F 867	Continued From page 46 concentration of sugar in the blood) according to manufacturer's recommendations before used to check the blood sugar (BS) of 2 of 2 residents observed (Resident #7, Resident #23). In addition, the facility failed to wear gloves prior to obtaining a droplet of blood for a blood sugar reading for 1 of 2 residents (Resident #7), and failed to clean/replace a dirty oxygen nasal cannula before reapplying for 1 of 1 residents (Resident #112) observed with oxygen administration via nasal cannula. The facility was recited F 880 for failing to: disinfect glucometers between resident use, not wearing gloves when coming in contact with blood, and not replacing oxygen tubing after being on the floor. F 880 was originally cited during the recertification and complaint survey of 02/17/17 for failure to follow droplet precautions per facility policy and procedure. During an interview on 03/02/18 at 7:45 PM, the Administrator revealed the quality assurance committee had determined the citations from the recertification and complaint investigation of 02/17/17 were met and it was decided to discontinue their monitoring.	F 867		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/8/18

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F 880	Continued From page 47 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 48 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician, and staff interviews the facility failed to disinfect a glucometer (a medical device used to determine the approximate concentration of sugar in the blood) according to manufacturer's recommendations before used to check the blood sugar of 2 of 2 residents observed (Resident #7, Resident #23). In addition, the facility failed to wear gloves prior to obtaining a droplet of blood for a blood sugar reading for 1 of 2 residents (Resident #7), and failed to clean/replace a dirty oxygen nasal cannula before reapplying for 1 of 1 residents (Resident #112) observed with oxygen administration via nasal cannula. 1. Immediate jeopardy began on 02/27/18 when Nurse #5 was observed commingling a used and unused glucometer in the same shirt pocket to collect blood samples for blood glucose readings from 2 residents without disinfecting the	F 880	F880 Infection Prevention and Control Corrective Action: On 2/27/18 surveyor reported to Director of Nursing (DON) that nurse obtained resident blood sugar in dining room with no gloves on. Surveyor also stated she observed nurse again approximately at 4:30 p.m. preforming blood sugar check on another resident and had 2 glucometers in her pocket. Nurse then proceeded to check another residents blood sugar without cleaning the glucometer. Surveyor stated she asked nurse to stop and nurse proceeded with procedure anyway. Director of Nursing immediately removed nurse from cart. Director of Nursing assigned another nurse to finish medication pass on this unit. Nurse that assumed cart ensured	

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F 880	Continued From page 49 glucometers. Immediate Jeopardy was removed 03/08/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential of more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to disinfecting glucometers and preventing transmission of blood borne pathogens. The other examples were not identified at an immediate jeopardy level. Findings included: 1 A. Review of the manufacturer's instructions of the germicidal (A substance or agent that kills germs, especially pathogenic microorganisms) wipes used to disinfect a glucometer revealed the following cleaning procedure: all blood and other body fluids must be thoroughly cleaned from surface (of the glucometer) before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three minutes. Use additional wipes if needed to assure continuous three minutes wet contact. Let air dry. During an observation on 02/27/18 at 4:50 PM, Nurse #5 had two glucometers placed in the same shirt pocket with no wrapping or barrier to prevent them from coming in contact with each other. She removed 1 glucometer from her pocket, donned gloves, and pierced Resident #23's finger with a retractable lancet and collected a drop of blood to complete a blood sugar reading. After she finished checking the	F 880	glucometer was clean and disinfected prior to using on residents. This incident was isolated to the nurse identified by surveyor. Director of Nursing then interviewed Nurse who was removed from cart regarding incident. Director of Nursing tried to review correct glucometer cleaning and disinfection procedure, and finger stick procedure with nurse. Nurse was and angry refused to listen and Director of Nursing placed her on suspension pending investigation of incident. Nurse then yelled to Director of Nursing she was resigning effective immediately. Nurse then walked out of facility. Nurse is no longer employed at facility. Medical Director was contacted and orders obtained to test both residents for HIV, Hepatitis C, and Hepatitis B now and repeat in 6 weeks and orders entered and completed on 3/8/18. Health Department was notified of above occurrence by Director of Nursing on 3/8/18. It is duly noted that Nurse #5 did not wear gloves while obtaining a blood sugar check on Resident #7 on 2/27/18. Nurse #5 no longer is employed at facility. It is duly noted that Nurse Aide #1 allowed oxygen tubing to touch the floor and continued using it until surveyor stopped him and told him to discard. Nurse Aide #1 received 1:1 education regarding not placing oxygen tubing back on resident if the tubing has touched the floor. Corrective Action for those having the potential to be affected:	

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F 880	Continued From page 50 blood, Nurse #5 was observed placing the glucometer she used for Resident #23, without disinfecting, in her shirt pocket with the other glucometer. During a continuous observation on 02/27/18 from 4:50 PM to 5:17 PM, Nurse #5 did not clean/disinfect either one of the glucometers she placed in her pocket. During an observation on 02/27/18 at 5:17 PM, Nurse #5 removed 1 of the glucometers from her pocket and donned gloves. She used a single use lancet to pierce the finger of Resident #7. When asked to stop, Nurse #5 stated she had cleaned/disinfected the glucometer prior to using the device on Resident #7 and continued to collect a drop of blood from Resident #7. Without disinfecting the glucometer, she used for Resident #7, she placed it in the same shirt pocket with the other glucometer. During an observation on 02/27/18 at 5:28 PM, Nurse #5 removed the two glucometers from her shirt pocket. She wiped both glucometers using a disinfecting wipe, then laid them on top of a new disinfecting wipe placed on her medication cart and covered them with a third wipe. At 5:29 PM, Nurse #5 removed both glucometers from under the disinfecting wipes and placed them in her shirt pocket where they continued to be in contact with each other with no barrier or wrapping. The glucometers were not observed to be wet for a full 3 minutes or completely dry before placing them in her pocket. During an interview on 02/27/18 at 5:29 PM, Nurse #5 explained she cleaned/disinfected glucometers by wiping with disinfecting wipes for	F 880	All residents with physician orders for blood glucose finger sticks were potentially at risk. All residents who wear oxygen are potentially at risk for infection control issues related to oxygen use. Systemic Changes: Fourteen of 22 licensed nurses were immediately educated on 2/27/18 and all other licensed nurses were in serviced prior to assuming their duties for their next scheduled shift on correct procedure for obtaining blood sugar finger sticks/glucometer cleaning and disinfection procedure. Procedure included gathering equipment, which included 1 glucometer placed in cup, alcohol prep pad, gloves, lancet, test strip, and extra cup before starting procedure. Reviewed with nurse the need to wash hands, placing a paper towel barrier down before setting supplies on over-bed table and donning gloves. Nurses educated on cleaning finger with alcohol swab prior to finger stick and process to complete blood glucose check. Nurses□ education included importance of removing gloves and washing hands when finished and disposing of lancet in blood-borne pathogen container after leaving room. Nurses then educated on procedure to clean and disinfect glucometer as follows: Remove sani-wipe container from bottom drawer of medication cart. Wipe glucometer down with sani- wipe and dispose of sani-wipe in trash. Remove another sani-wipe from container and wrap glucometer in sani-wipe and place in cup for at least 3 minutes on top of	

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F 880	Continued From page 51 30 seconds. She explained carrying 2 glucometers in her pocket made it quicker for her to check residents blood sugars. She further explained she would check 2 residents and then would clean/disinfect the glucometers. When asked how she would know which glucometer she used for which resident, she confirmed she could not identify which glucometer was used and which one was not. Nurse #5 was unaware of the manufacturer's instructions to keep the surface area of the glucometer wet for a full 3 minutes and let air dry. During an interview on 02/27/18 at 5:35 PM, the Director of Nursing (DON) explained the facility used multiuse glucometers to check blood sugars for residents. The DON revealed her expectation was for the nurse to carry 1 glucometer for each finger stick and after use to clean/disinfect the device. A second clean/disinfected glucometer was used to allow nurses the time needed to clean/disinfect glucometers between residents. The DON further explained this procedure allowed the appropriate time needed to disinfect one device while using the other device. During an additional interview on 03/02/18 at 6:19 PM, the DON revealed it was her expectation for the nurses to follow the manufacturer's instructions when cleaning/disinfecting glucometers after each use. The DON, Quality Transition Specialist, and Clinical Resource Specialist were informed of Immediate Jeopardy on 03/07/18 at 6:06 PM related to glucometers not being disinfected according to manufacturer's instructions after each use and putting glucometers in contact with each other before disinfecting after use.	F 880	medication cart. After 3 minutes remove from cup and unwrap from sani-wipe, then place glucometer in dry cup to dry for at least 2 minutes. Nurse then educated on placing dry glucometer back in medication cart. Director of Nursing will provide in-servicing to licensed and certified staff to include infection control practices related to oxygen use to include throwing away oxygen tubing that has touched the floor. Monitoring: Finger stick/blood sugar policy was updated on 3/7/2018 to include specific time for glucometer to remain wet and air dry. Competency audits were initiated on 3/7/2018 by Quality Assurance Nurse and Regional MDS Specialist with 12 of 22 nurses completed. All other nurses will have competency of finger stick and glucometer cleaning completed prior to assuming their duties as charge nurse by Nurse Managers until 100% of licensed nurses completed. Director of Nursing will ensure a finger stick (to include appropriate glove donning) and glucometer cleaning and disinfecting audits are completed on one nurse per shift weekly times 4 weeks and then monthly times 4 months by nurse management. Director of Nursing or designee will complete 5 competency questioning audits of licensed and certified staff weekly for 4 weeks and then 5 competency questioning audits monthly for 4 months to determine if staff respond	

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F 880	Continued From page 52 On 03/08/18 at 11:29 AM, the facility provided the following Credible Allegation of Compliance. On 2/27/18 surveyor reported to Director of Nursing (DON) that nurse obtained resident blood sugar in dining room with no gloves on. Surveyor also stated she observed nurse again approximately at 4:30 p.m. performing blood sugar check on another resident and had 2 glucometers in her pocket. Nurse then proceeded to check another residents blood sugar without cleaning the glucometer. Surveyor stated she asked nurse to stop and nurse proceeded with procedure anyway. Director of Nursing immediately removed nurse from cart. Director of Nursing assigned another nurse to finish medication pass on this unit. Nurse that assumed cart ensured glucometer was clean and disinfected prior to using on residents. This incident was isolated to the nurse identified by surveyor. Director of Nursing then interviewed Nurse who was removed from cart regarding incident. Director of Nursing tried to review correct glucometer cleaning and disinfection procedure, and finger stick procedure with nurse. Nurse was and angry and refused to listen and Director of Nursing placed her on suspension pending investigation of incident. Nurse then yelled to Director of Nursing she was resigning effective immediately. Nurse then walked out of facility. Nurse is no longer employed at facility. Medical Director was contacted and orders obtained to test both residents for HIV, Hepatitis C, and Hepatitis B now and repeat in 6 weeks and orders entered and completed on 3/8/18. Health Department was notified of above occurrence by Director of Nursing on 3/8/18.	F 880	appropriately to infection control practices related to oxygen use. Any discrepancies will be brought to the Director of Nursing for reeducation. Facility Administrator will insure Quality Assurance Process Improvement Plan for finger stick/glucometer cleaning will be reviewed at Quality Assurance Committee and revised as needed. The title of the person responsible for implementing the acceptable plan of correction for Facility F Tag 880 is the Director of Nursing.	

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F 880	Continued From page 53 All residents with physician orders for blood glucose finger sticks were potentially at risk. Fourteen of 22 licensed nurses were immediately educated on 2/27/18 and all other licensed nurses were in serviced prior to assuming their duties for their next scheduled shift on correct procedure for obtaining blood sugar finger sticks/glucometer cleaning and disinfection procedure. Procedure included gathering equipment, which included 1 glucometer placed in cup, alcohol prep pad, gloves, lancet, test strip, and extra cup before starting procedure. Reviewed with nurse the need to wash hands, placing a paper towel barrier down before setting supplies on over-bed table and donning gloves. Nurses educated on cleaning finger with alcohol swab prior to finger stick and process to complete blood glucose check. Nurses' education included importance of removing gloves and washing hands when finished and disposing of lancet in blood-borne pathogen container after leaving room. Nurses then educated on procedure to clean and disinfect glucometer as follows: Remove sani-wipe container from bottom drawer of medication cart. Wipe glucometer down with sani- wipe and dispose of sani-wipe in trash. Remove another sani-wipe from container and wrap glucometer in sani-wipe and place in cup for at least 3 minutes on top of medication cart. After 3 minutes remove from cup and unwrap from sani-wipe, then place glucometer in dry cup to dry for at least 2 minutes. Nurse then educated on placing dry glucometer back in medication cart. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	F 880		

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F 880	Continued From page 54	F 880		

Finger stick/blood sugar policy was updated on 3/7/2018 to include specific time for glucometer to remain wet and air dry. Competency audits were initiated on 3/7/2018 by Quality Assurance Nurse and Regional MDS Specialist with 12 of 22 nurses completed. All other nurses will have competency of finger stick and glucometer cleaning completed prior to assuming their duties as charge nurse by Nurse Managers until 100% of licensed nurses completed.

Director of Nursing will ensure a finger stick and glucometer cleaning and disinfecting audits are completed on one nurse per shift weekly times 4 weeks and then monthly times 4 months by nurse management. Any discrepancies will be brought to the Director of Nursing for reeducation. Facility Administrator will insure Quality Assurance Process Improvement Plan for finger stick/glucometer cleaning will be reviewed at Quality Assurance Committee and revised as needed.
The title of the person responsible for implementing the acceptable plan of correction for F Tag 880
Director of Nursing is responsible for implementing the credible allegation.

Immediate Jeopardy was removed on 03/08/18 at 12:33 PM when observations and interviews revealed nurses were knowledgeable about disinfecting glucometers and how to properly store the devices. Nurses demonstrated how to obtain blood sugar readings and disinfect glucometer devices after each use as recommended by the manufacturer's instructions on the wipes provided by the facility.

2. Review of the facility Infection Control Manual

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dated 03/05, concerning Using Gloves read in part: the facility will ensure the use of gloves for protection to prevent contamination of the employee's hands when providing treatment or services. Procedure: Gloves should be used when touching blood, body fluids, or non-intact skin and if the possibility hands came in contact with blood, body fluids, or other potentially infectious material.

During an observation on 02/27/18 at 12:18 PM, Nurse #5 pierced the finger of Resident #7 to obtain a droplet of blood for a blood sugar reading. She was not wearing gloves during the procedure.

During an interview on 02/27/18 at 12:18 PM, Nurse #5 explained Resident #7 was about to start eating lunch and the BS needed to be checked before eating, so she quickly collected a drop of blood without wearing gloves due to being in a hurry. Nurse #5 confirmed she should have donned gloves prior to collecting a drop of blood to determine a blood sugar reading for Resident #7.

During an interview on 03/02/18 at 6:19 PM, the Director of Nursing revealed it was her expectation for nurses to follow the facility policy and wear gloves when checking a resident's blood sugar.

3. During a continuous observation on 03/01/18 beginning at 12:19 PM of Resident #112 receiving ADL care that included incontinence care, hygiene, grooming and dressing. Nurse Aide (NA) #1 was observed removing the nasal cannula from Resident #112's nose and the oxygen tubing from his ears and laid it at the head of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(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
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While NA #1 was assisting Resident #112 to dress, the nasal cannula was observed falling off the bed onto the floor with the cannula openings touching the floor. NA #1 was observed to pick up the nasal cannula after a minute had passed and laid the tubing back across the head of the bed. NA #1 continued to assist Resident #112 with dressing then assisted him to transfer from his bed to his wheelchair. After Resident #112 was settled in his wheelchair, NA #1 was observed removing the nasal cannula tubing from the bed, disconnected it from the oxygen concentrator and attached it to the portable oxygen unit on the back of the wheelchair. NA #1 was in process of placing the oxygen on Resident #112 when he was told to stop. NA #1 was asked if he should place the nasal cannula back in the nose of Resident #122. NA #1 did not know why he should not have placed the nasal cannula on Resident #112. NA #1 stated he had not realized the oxygen tubing had fallen to the floor and it was just a reflex to pick it up and put it back across the bed until he was finished dressing and transferring Resident #122 to his wheelchair.

During an interview with NA #1 on 03/01/18 at 12:35 PM, NA #1 stated he should have replaced the oxygen tubing and not attempted to place the nasal cannula tubing back on the resident without changing it.

During an interview with the DON on 03/02/18 at 6:43 PM, the DON stated her expectations were for the NA to discard the dropped oxygen tubing and replace it with new tubing for Resident #112.