STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345219	A. BUILDING ______ B. WING ______	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA LANE NURSING AND REHABILITATION CENTER	**107 MAGNOLIA DRIVE MORGANTON, NC 28655**

(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 survey and complaint investigation (Event ID #4N6D11) was conducted on 08/27/18 through 08/30/18. Immediate jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity of J. Tags F689 constituted substandard quality of care. Immediate jeopardy began on 03/08/18 and was removed on 08/30/18. An extended survey was completed. There were no deficiencies cited as a result of the complaint investigation.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		8/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/24/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, resident interviews and staff interviews, the facility failed to honor to choices to smoke independently and at the time of their choosing for 3 of 3 sampled residents who were assessed as being safe to smoke independently (Residents #28, #37 and #38).

The findings included:

1. Resident #28 was readmitted to the facility on 07/19/18. His diagnoses included pleural effusion, chronic obstructive pulmonary disease, anxiety disorder and rheumatoid arthritis.

The admission Minimum Data Set (MDS) dated 07/26/18 coded his cognition as not being able to be assessed and being independent for bed mobility, transfers, eating, toileting and ambulation. He was coded as having no behaviors and using tobacco.

According to pain Care Area Assessment (CAA) dated 07/26/18, Resident #28 was alert and oriented and could communicate his wants and needs. He was independent with most of his

F 561

Magnolia Lane nursing and rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Magnolia Lane nursing and rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Magnolia Lane reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F561

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activities of daily living skills.

A Smoking Evaluation dated 08/02/18 revealed Resident #28 was a safe smoker and may smoke independently at this time. He was also noted to receive education on the smoking policy and was in agreement to follow the policy. The form indicated the care plan was reviewed and revised on 08/03/18 and completed by Nurse #4.

A care plan dated 08/22/18 initiated by the Assistant Director of Nursing revealed he was care planned as an unsafe smoker and could only smoke at designated facility times with direct supervision.

Resident #28 was observed smoking under supervision on 08/27/18 at 11:02 AM and again on 08/27/18 at 4:18 PM.

During an interview conducted on 08/27/18 at 9:50 AM, Resident #28 stated he was upset about the designated smoking times.

On 08/28/18 at 8:55 AM, Nurse Aide (NA) #2 was observed to have the box of smoking materials and was observed taking the residents out to smoke. She revealed there are no residents permitted to smoke independently and they are permitted 2 cigarettes at each designated smoke time.

Resident #28 was observed to be supervised when smoking on 08/28/18 at 1:30 PM.

On 08/28/18 at 3:00 PM, Resident #28 stated that he had never been permitted to smoke unsupervised since he was admitted and was never told why.

F 561

The position of Magnolia Lane nursing and rehabilitation center regarding the process that lead to this deficiency-failure to honor choices to smoke independently and at the time of their choosing for residents who were assessed to be safe smokers- was staff knowledge deficit related to resident the procedure for independent smokers.

On 8/30/18 resident # 28 was reviewed and was determined to remain a safe, independent smoker. On 8/30/18 resident began smoking at their desired time.
On 8/30/18 resident # 37 was reviewed and was determined to remain a safe, independent smoker. On 8/30/18 resident began smoking at their desired time.
On 8/30/18 resident # 38 was reviewed and was determined to remain a safe, independent smoker. On 8/30/18 resident began smoking at their desired time.

Beginning 8/27/18 with completion on 8/30/18 the director of nursing (DON) completed a review of all smokers in the facility to determine status (independent or dependent). 3 of 3 negative findings were immediately addressed by DON.
On 8/29/18 the assistant director of nursing (ADON) began an in-service with licensed nursing staff on independent smokers, including choice of time. This in-service was completed by 8/30/18.
After 8/30/18 no licensed nurse was allowed to work until in-service is

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Resident #28 was observed smoking under supervision on 08/28/18 at 4:06 PM.

The Director of Nursing (DON) was interviewed on 08/29/18 at 2:30 PM. The DON stated smoking assessments are usually completed by the admitting nurse and then by the MDS nurses. The DON confirmed that there have been no residents permitted to smoke independently until this date when the facility was looking at Resident #28's ability to smoke independently. She further stated that staff were confused about the smoking policy. She stated that staff just thought that any smoker needed to be supervised when smoking and when she arrived at the facility in June 2018, she was informed that all residents needed to be supervised while smoking. The DON further stated that staff, including herself, were not instructed on how to fill out the smoking assessments.

An interview conducted on 08/29/18 at 2:40 PM with the Administrator revealed he was told by staff when he arrived at the facility to work as the Administrator in June 2018 that all smokers were supervised. He stated he never questioned why and assumed that it was facility policy. He stated all smokers had been reassessed today and Resident #38 was assessed as a safe smoker and she would be allowed to smoke independently when she wanted to smoke.

Again on 08/29/18 at 3:13 PM Resident #28 stated he could not understand why he was not permitted to smoke per his choice since admission because he was alert and safe. He further stated the Administrator was just in and told him he can smoke independently.

F 561

complete. This in-service will be part of the orientation for newly hired licensed nurses.

The DON, ADON, and/or administrator will interview 50% of independent smokers (determined by the smoking assessment) weekly x 12 weeks to ensure they are being allowed to smoke at times of their choice. This audit will be documented on the independent smokers audit tool.

The monthly QI committee will review the results of the independent smokers audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The Director of nursing is responsible for implementing the acceptable plan of correction.

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2. Resident #37 was admitted to the facility on 07/30/18. His diagnoses included fractured tibia, and nicotine dependence.
A care plan was developed on 07/31/18 indicating he was an independent smoker and may smoke at his own times without supervision.

Resident #37's Smoking Evaluation dated 08/02/18 revealed the outcome was that he was a safe smoker and may smoke independently at this time and that education on the smoking policy was provided.

His admission Minimum Data Set (MDS) dated 08/06/18 coded him with having intact cognition and no behaviors and requiring supervision with most activities of daily living skills.

Resident #37 was observed outside on 08/27/18 at 4:18 PM smoking with supervision.

On 08/27/18 at 5:27 PM Resident #37 was interviewed. He stated that he was only permitted to smoke at designated times under supervision only. He further stated he would like to smoke whenever he wanted but stated it may cause staffing problems.

Another Smoking Evaluation dated 08/28/18 revealed the outcome was that he was a safe smoker and may smoke independently at this time and that education on the smoking policy was provided.

The Director of Nursing (DON) was interviewed on 08/29/18 at 2:30 PM. The DON stated smoking assessments are usually completed by the admitting nurse and then by the MDS nurses.

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F 561	Continued From page 5 The DON confirmed that there have been no residents permitted to smoke independently until this date when the facility was looking at Resident #37's ability to smoke independently. She further stated that staff were confused about the smoking policy. She stated that staff just thought that any smoker needed to be supervised when smoking and when she arrived at the facility in June 2018, she was informed that all residents needed supervision when they smoked. The DON further stated that staff, including herself, were not instructed on how to fill out the smoking assessments. An interview conducted on 08/29/18 at 2:40 PM with the Administrator revealed he was told by staff when he arrived at the facility to work as the Administrator in June 2018 that all smokers were supervised. He stated he never questioned why and assumed that it was facility policy. He stated all smokers had been reassessed today and Resident #38 was assessed as a safe smoker and she would be allowed to smoke independently when she wanted to smoke. 3. Resident #38 was admitted to the facility on 07/30/18 with diagnoses of high blood pressure, Multiple Sclerosis, diabetes, and a fracture. Review of the admission Minimum Data Set (MDS) dated 08/06/18 revealed Resident #38 was cognitively intact and coded with having no behaviors. Review of the Smoking Assessment dated 08/02/18 revealed Resident #38 was a safe smoker and could smoke independently. She was also noted to receive education on the smoking policy and was in agreement to follow the policy.	F 561		

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F 561	Continued From page 6	F 561		

Resident #38 was observed on 08/28/18 at 11:05 AM and 08/29/18 at 4:20 PM smoking with supervision.

During an interview conducted on 08/28/18 at 12:50 PM, Resident #38 stated she was only allowed to smoke at the facility supervised times and she would like to be able smoke more often or at different times.

An interview conducted on 08/28/18 at 8:55 AM with Nurse Aide (NA) #2 revealed there were no residents permitted to smoke independently and they were permitted 2 cigarettes at each designated smoke time.

An interview conducted on 08/29/18 at 2:30 PM with the Director of Nursing (DON) revealed the smoking assessments were usually completed by the admitting nurse and then the MDS Nurses. The DON confirmed that there were no residents permitted to smoke independently until this date, when the facility began looking at residents who were assessed as safe smokers' ability to smoke independently. She stated that the staff were confused about the smoking policy and they thought all smokers needed to be supervised when smoking. She stated she was told when she arrived at the facility to work as the DON in June 2018 all residents had to be supervised when smoking and she had not questioned why. The DON stated that staff, including herself, had not been instructed on how to fill out the smoking assessment. She further stated all smokers had been reassessed today and Resident #38 was assessed as a safe smoker and would be allowed to smoke independently.

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F 561	Continued From page 7 An interview conducted on 08/29/18 at 2:40 PM with the Administrator revealed he was told by staff when he arrived at the facility to work as the Administrator in June 2018 that all smokers were supervised. He stated he never questioned why and assumed that it was facility policy. He stated all smokers had been reassessed today and Resident #38 was assessed as a safe smoker and she would be allowed to smoke independently when she wanted to smoke.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		9/28/18

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F 583	Continued From page 8 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to prevent the possible exposure of a resident's body by failing to pull the privacy curtains around a resident during the provision of a shower and failing to knock on the shower room door or ask permission before entering the shower room for 1 of 1 residents (Resident #33) observed receiving a shower. The findings included: Resident #33 was admitted to the facility on 09/06/13 with diagnoses which included chronic obstructive pulmonary disease, chronic kidney disease, and heart failure. Review of a Minimum Data Set (MDS) dated 04/03/18 indicated Resident #33 was mildly cognitively impaired and required physical help in part of bathing. Observation of the shower room on 08/30/18 at 4:00PM revealed it was equipped with a code system on the door and a tab on the wall beside the door to indicate if the shower was vacant or in use. The shower room was also equipped with privacy curtains in front of the shower stall as well as in the main part of the shower room.	F 583	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to deficiency of failure prevent the possible exposure of a residents body by failing to pull the privacy curtain, knock before entering the shower room, or ask permission before entering the shower room-was staff knowledge deficit regarding providing personal privacy. On 8/30/18 resident # 33□s privacy was not impaired because resident was dressed when staff entered shower room. Resident # 33 was observed by the 9/24/18 by DON while in the shower room. The privacy curtain was pulled, and staff was noted to knock and wait for permission prior to entering. By 9/28/18 all staff will be observed by the director of nursing (DON), assistant director of nursing (ADON), or administrator for correct procedure to protect resident privacy (knocking, and waiting for permission to enter resident room). This observation will be documented on an employee roster. After 9/28/18 no staff will be allowed to work until observation is completed.	

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F 583 Continued From page 9

Observations during Resident #33's shower on 08/30/18 at 4:06PM revealed a laundry aide entered the code into the code system on the shower room door and entered the room without asking permission to enter. The tab on the wall beside the shower room door indicated the shower room was in use. When the laundry aide opened the shower room door Resident #33, although clothed by this time, was visible from the hallway as the privacy curtains were not pulled.

During an interview on 08/30/18 at 4:20PM with the nurse aide (NA) #3, who was assisting Resident #33 with his shower on 08/30/18, she stated she does not pull the privacy curtains during his showers because Resident #33 has never requested the privacy curtains be pulled.

During an interview with Resident #33 on 08/30/18 at 4:30PM he indicated staff do not pull the privacy curtains in the shower room during his showers and staff frequently come in and out of the shower room during his showers without knocking or asking permission to come in. Resident #33 stated that made him feel embarrassed to have others see him naked.

An interview with the laundry aide on 08/30/18 at 5:30PM revealed laundry and housekeeping staff have the code to the shower room because they clean the room and collect the dirty linen. She indicated she had entered the shower room to collect the dirty linen during Resident #33's shower. When asked how she would know if someone was getting a shower when she went in to get the dirty linen she reported the sign on the

F 583

By 9/28/18 all nursing staff will be observed by the director of nursing (DON), assistant director of nursing (ADON), or administrator for correct procedure to protect resident privacy and prevent possible exposure of a resident�s body (pulling privacy curtain). This observation will be documented on an employee roster. After 9/28/18 no nursing staff will be allowed to work until observation is completed.
All staff will be in-serviced by the ADON, or DON by 9/28/18 on providing resident privacy including knocking and waiting for response prior to entering a room, and pulling the privacy curtain when a resident�s body will be exposed. This in-service will be complete by 9/28/18. No staff will be allowed to work after 9/28/18 until in-service has been completed. This in-service will be part of the orientation for all newly hired staff.

The DON, ADON, social worker, or administrator will observe 10 opportunities to ensure resident privacy is maintained (knocking and waiting for permission before entering closed doors, privacy curtains pulled, etc.) weekly x 12 weeks on varying days and shifts (to include nights, and weekends). This audit will be documented on the privacy audit tool.
The monthly QI committee will review the results of the privacy audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The

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F 583	Continued From page 10 outside of the door would say someone was in there or she would knock and staff would let her know if she could go in because sometimes the curtains are pulled and the linen is right inside the door. She further added, sometimes she forgets to check the sign on the door or knock on the door. When asked if she knocked before entering the shower room during Resident #33's shower she stated she did not but the curtains were pulled in the shower room, so she went on in. In an interview with the Administrator on 08/30/18 at 5:41PM he indicated his expectation was that staff would knock on the shower room door and wait for a response before entering the shower room.	F 583	administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction.	
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 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.	F 584		9/24/18

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F 584	Continued From page 11 §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 and staff interviews, the facility failed to ensure resident personal care equipment was stored clean, safely and properly labeled in 4 bathrooms affecting 7 residents on 1 of 2 halls. (Bathrooms adjoining Room 106, Room 108, Room 110/111, and Room 112 on the Central hall). The findings included: Personal Care equipment was observed not labeled and/or stored clean as follows: 1. Room 106's bathroom shared by 2 residents was observed to have an unlabeled, uncovered 3 sided graduated cylinder on the shelf above the commode and a constantly dripping sink. This	F 584	The position of Magnolia Lane Nursing and rehabilitation center regarding the process that lead to this deficiency-failure to ensure resident personal care equipment was stored clean, safely, and properly labeled- was staff knowledge deficit related to labeling, and storage of personal items; and repair of leaking sink. On 8/30/18 the Director of Nursing (DON) discarded the unlabeled, and uncovered 3 sided graduated cylinder in room 106s bathroom. On 8/31/18 maintenance repaired the leaking sink in room 106 bathroom. On 8/30/18 the DON discarded the unlabeled, and uncovered urine hat in	

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was observed on 08/27/18 at 9:45 AM, on 08/28/18 at 11:42 AM, on 08/28/18 at 2:59 PM, and on 08/30/18 at 6:37 PM.

On 08/30/18 at 6:37 PM, the Administrator and Director of Nursing stated the cylinder should be labeled and covered and the sink will be fixed.

2. Room 108's bathroom shared by Room 109 and by one female and one male resident was observed to have an unlabeled, uncovered urine hat with dried yellow residue on the inside located on the handrail on 08/27/18 at 11:39 AM. On 08/28/18 at 3:04 PM the unlabeled soiled urine hat remained uncovered on the handrail and there was a white brush with lots of hair in the bristles that was unlabeled on the back of the commode. On 08/29/18 at 9:26 AM, this bathroom had the same uncovered, unlabeled soiled urine hat on the handrail, the same unlabeled used hair brush on the back of the commode and had 3 wash basins unlabeled upside down on the bathroom floor. In addition there was a covered unlabeled green bedpan on the floor behind the commode. All this remained in place during an observation on 08/30/18 at 9:22 AM and on 08/30/18 at 6:39 PM.

On 08/30/18 at 6:39 PM, the Administrator and Director of Nursing verified the presence of the equipment and stated items should be labeled and bagged and stored clean.

3. Room 110 and Room 111's shared bathroom, which was shared by 3 men, was observed on 08/27/18 at 11:54 AM to have 2 unlabeled disposable razors on the back of the commode, an uncovered and very stained urinal on the handrail and an uncovered unlabeled fracture pan

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room 108s bathroom.
On 8/30/18 the DON discarded the unlabeled white brush in room 108s bathroom.
On 8/30/18 the DON discarded the unlabeled green bedpan in room 108s bathroom.
On 8/30/18 the DON discarded the 2 unlabeled disposable razors in room 110 and 111s shared bathroom.
On 8/30/18 the DON discarded the uncovered urinal in room 110 and 111s shared bathroom.
On 8/30/18 the DON discarded the uncovered and unlabeled fracture pan in room 110 and 111s shared bathroom.
On 8/30/18 the DON discarded the 2 uncovered and unlabeled wash basins in room 112s bathroom.

On 9/4/18 Administrator, Director of Nursing, Assistant Director of Nursing, Housekeeping manager, Accounts Payable, Accounts Receivable, maintenance, medical records, and Minimum Data Set RN completed a 100% audit of the facility to ensure 1. All personal items are labeled, covered, and clean; 2. If any sinks are leaking.
Findings: All items were labeled, covered, and clean, if not they were discarded/labeled and no other sinks were found to be leaking.
On 9/4/18 the assistant director of nursing (ADON) began an in-service with all nursing staff on labeling, covering, and ensuring all personal items are clean. This

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on the shelf above the commode. During observations on 08/28/18 at 3:04 PM the fracture pan was unlabeled but covered on the shelf and the soiled urinal was covered on the handrail. The two razors remained unlabeled and on the back of the commode. These items remained as described during observations on 08/29/18 at 1:59 PM, on 08/30/18 at 10:22 AM, and when observed with the Administrator and Director of Nursing on 08/30/18 at 6:43 PM.

The Administrator and Director of Nursing stated on 08/30/18 at 6:43 PM personal care equipment should be labeled and stored clean and the razors should not be on the back of the commode.

4. Room 112'S bathroom shared by 2 men was observed to have 2 stacked, uncovered and unlabeled wash basins located on a shelf above the commode on 08/27/18 at 10:53 AM. The two wash basins remained unlabeled and one was soiled with brown matter on 08/28/18 at 11:43 AM. These wash basins remained uncovered, unlabeled and soiled during observations made on 08/30/18 at 10:23 AM and on 08/30/18 at 6:50 PM.

On 08/30/18 at 6:50 PM the Administrator and Director of Nursing observed these items and stated the wash basins should be clean, labeled and covered.

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in-service will be complete by 9/24/18. After 9/24/18 no staff will be allowed to work until in-service is completed. This in-service will be part of the orientation for new nursing staff.

On 9/24/18 the administrator in-serviced the maintenance director on ensuring all sinks are in proper working order, including no constant leaking. This in-service will be part of the orientation for any new maintenance employees.

The administrator, ADON, director of nursing, social worker, maintenance director, accounts receivable, payroll, social worker, activity director, and or licensed nurse will audit 25% of resident rooms weekly x 12 weeks, including bathrooms, to ensure 1. All resident care items are labeled, covered, and cleaned, and 2. The sink is not leaking. This audit will be documented on the Department Head Round audit tool.
The monthly QI committee will review the results of the Department Head Round audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

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F 584	Continued From page 14	F 584	The Administrator is responsible for implementing the acceptable plan of correction.	
F 636 SS=E	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: (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	F 636		9/28/18

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F 636	Continued From page 15 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 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 record review, resident interview and staff interviews, the facility failed to complete the Minimum Data Sets (MDS) and/or complete the Care Area assessments (CAA) that addressed the underlying causes, contributing factors and risk factors to be considered in developing individual care plans interventions. This affected 12 of 22 resident sampled for review of MDS and CAA. (Residents #13, #14, #22, #23, #26, #28, #29, #33, #42, #43 and #44). The findings included:	F 636	F636 Comprehensive Assessments and Timing The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately completing the Minimum Data Sets (MDS) and/or complete the Care Area Assessments (CAA's) that addressed the underlying	

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1. Resident #23 was admitted to the facility on 08/27/18. Her diagnoses included hypertension, chronic obstructive pulmonary disease, dementia, depression, and neuropathy.

a. The annual Minimum Data Set dated 07/12/18 noted section C for the Brief Interview for Mental Status was marked as "Not assessed" either for the resident interview or the staff assessment. In addition section D related to mood was marked "not assessed" for both the resident interview and staff assessment. Pain was coded as her receiving routine pain medications and was in almost constant pain which she rated 8 out of a scale of 10 with 10 being the worst.

Interview with the Social Worker on 08/30/18 at 4:50 PM revealed he had been employed at the facility since the beginning of June 2018. He stated that he was just recently trained on the MDS sections he was responsible for including sections C and D and began doing theses sections at the beginning of August. The Social Worker stated the MDS nurse, a corporate employee, instructed him that if the sections were not completed within the required time frame he was to enter "not assessed". He stated that was why the MDS sections were not assessed.

Interview with the Administrator on 08/30/18 at 4:56 PM revealed that he would have expected the MDS nurse to complete those sections knowing the social worker was not yet trained and doing that assignment.

b. The Care Area Assessment (CAA) for pain dated 07/27/18 stated under the analysis the resident was alert and oriented with periods of

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causes, contributing factors and risk factors to be considered in developing individual care plan interventions.

On 9/25/18 the Social Worker (SW) completed a mental status assessment and on 9/10/18 mood interview for resident # 23 and documented the findings in resident # 23's medical record.

On 9/23/18 a general care plan note for resident #23 was completed by the facility MDS consultant addressing resident # 23s pain. All documentation includes a description of the focus of specific CAA triggered including causes, contributing factors, and risk factors to include pain medication effectiveness, the need for as needed pain medication and how pain affected her activities of daily living.

Resident # 28 was discharged home from facility 8/31/18.

Resident # 42 was discharged from facility 9/21/18.

On 9/23/18 a general care plan note for resident #44 was completed by MDS consultant addressing resident # 44s psychoactive medications. All documentation includes a description of the focus of specific CAA triggered including causes, contributing factors, and risk factors to include analysis of if the medication is effective and the presence of side effects.

On 8/14/18 the DON completed a resident

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F 636	Continued From page 17 confusion, and she was able to perform her own activities of daily living and would ask if she needed assistance. She walked with a walker and toileted herself. The CAA stated the resident reported having pain daily. The CAA failed to address if the routine pain medication was effective, if she required as needed pain medication and how the pain affected her day to day function. On 08/27/18 at 11:36 AM Resident #23 stated she received pain medication in the mornings and at night but needed more pain medication. On 08/29/18 at 18 at 9:25 AM Resident #23 asked the surveyor when her pain medication was due. Nurse #5 stated on 08/29/18 immediately following this interaction that Resident #23 received routine pain medication and would get it soon. On 08/30/18 at 8:15 AM, Resident #23 again asked the surveyor if it was time for her pain medications. Interview with the MDS representative on 08/30/18 at 5:48 PM revealed that the check marks on the CAA that noted pain limited her day to day activity and the check mark that she suffered from musculoskeletal arthritis was how the nurse who completed the CAA analyzed the information. He stated different nurses analyze the information differently. 2. Resident #28 was readmitted to the facility on 07/19/18. His diagnoses included rheumatoid arthritis, chronic obstructive pulmonary disease, and anxiety.	F 636	pain interview with resident # 44 and documented the findings in resident # 44's medical record. On 7/10/18 the Social Worker (SW) completed a mental status assessment for resident # 43 and documented the findings in resident # 43s medical record. On 7/6/18 the Social Worker (SW) completed a mental status assessment for resident # 22 and documented the findings in resident # 22s medical record. On 9/8/18 the Social Worker (SW) completed a mental status assessment for resident # 29 and documented the findings in resident # 29s medical record. On 9/25/18 the Social Worker (SW) completed a mental status assessment and mood interview for resident # 13 and documented the findings in resident # 13's medical record. On 7/4/18 the Social Worker (SW) completed a mental status assessment and mood interview for resident # 14 and documented the findings in resident # 14's medical record. On 8/1/18 the Social Worker (SW) completed a mental status assessment for resident # 26 and documented the findings in resident # 26's medical record. On 8/8/18 the Social Worker (SW) completed a mental status assessment and on 9/25/18 mood interview for	

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a. The Minimum Data Set (MDS), an admission dated 07/26/18, coded section C, his cognition, as not being assessed by resident interview or by staff evaluation, section C related to delirium was not assessed and Section D on mood was not assessed by resident interview or by staff evaluation. In addition, participation in the assessment was also not assessed and he was coded as having received 7 days of antianxiety medications in the previous 7 days.

Interview with the Social Worker on 08/30/18 at 4:50 PM revealed he has been employed at the facility since the beginning of June 2018. He stated that he was just recently trained on the MDS sections he was responsible for including sections C and D and began doing theses sections at the beginning of August. The Social Worker stated the MDS nurse, a corporate employee, instructed him that if the sections were not completed within the required time frame he was to enter "not assessed". He stated that was why the MDS sections were not assessed.

Interview with the Administrator on 08/30/18 at 4:56 PM revealed that he would have expected the MDS nurse to complete those sections knowing the social worker was not yet trained and doing that assignment.

b. The Care Area Assessment (CAA) related to psychoactive medications dated 08/01/18 listed that he received Buspar (an antianxiety medication) 20 milligrams daily. The CAA then listed he potential side effects. There was no analysis of if the medication was effective or if he was having any side effects.

Interview with the MDS representative on

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resident # 33 and documented the findings in resident # 33's medical record.

On 9/23/18 the MDS consultant began auditing each resident CAA that triggered for pain, nutritional status, or psychotropic drug use for the past 30 days to ensure all CAA was completed accurately. A detailed general care plan progress note was completed for each resident where a concern was noted. The audit was completed on 9/24/18.
On 9/25/18 began auditing all completed MDS assessments for the past 30 days to ensure each resident had a mental status assessment and mood interview completed accurately. A mental status assessment and/or a mood interview was completed and documented in the resident medical record if there was a concern noted.
On 9/6/18 the facility consultant completed an in-service with the director of nursing, assistant director of nursing, social worker, and administrator on Section V-Care Area Assessments (CAA Summary) you must meet the requirements by describing the resident's clinical status including a description of the problem, contributing factors, risk factors, and an analysis of findings impacting care plan decisions. The analysis should include goals and interventions. Care plan and CAA should be resident specific. You should refer to the RAI manual or facility MDS consultant for questions or guidance.

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08/30/18 at 5:48 PM revealed that the CAA listed potential side effects and that Resident #28 had a diagnosis of anxiety. He states some nurses bundle and analyze information differently. The MDS representative stated it was alright with him.

3. Resident #42 was readmitted to the facility on 05/29/18. Her diagnosis included chronic kidney disease, above knee amputation, diabetes, sepsis, wound infection, anxiety and depression. The Admission Minimum Data Set dated 06/05/18 coded her as requiring extensive assistance with most activities of daily living skills, supervision with eating, receiving a therapeutic diet and weighing 205 pounds.

The Care Area Assessment (CAA) dated 06/06/18 gave no analysis of the resident's strengths, weaknesses, underlying causes, contributing factors and risk factors to be considered in developing individual care plans interventions. Under the section for the nature of the problem was to see Section K on the MDS and under the description of the problem stated to see the nutritional care plan.

Interview with the MDS representative on 08/30/18 at 5:48 PM revealed the CAA did not have the required information to explain the issue or why a nutritional care plan was being developed.

4. Resident #44 was admitted to the facility on 03/13/15 and most recently on 05/15/18. His diagnoses included Alzheimer's Disease, insomnia, orthostatic hypotension, chronic kidney disease and major depressive disorder.

a. The annual Minimum Data Set (MDS) dated

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The director of nursing, assistant director of nursing, and/or administrator will audit 5 completed and transmitted comprehensive assessments to include the CAA's triggered for pain, nutritional status, and psychotropic drug use to ensure they are completed accurately. This audit will be completed weekly x 12 weeks using the MDS Audit Tool.
The director of nursing, assistant director of nursing, and/ or administrator will audit 5 completed and transmitted MDS assessments to ensure the resident mental status assessment and mood interviews were completed using the MDS audit tool weekly x 12 weeks.

The director of nursing will present all findings from the MDS audit tool at the monthly QI committee. The monthly QI committee will review the results of the MDS Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The director of nursing is responsible for implementing the acceptable plan of correction.

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02/12/18 coded him as receiving antianxiety medication and antidepressant medications 7 days out of the previous 7 days and no hypnotics in the previous 7 days.
The Care Area Assessment (CAA) dated 02/15/18 noted he received Ativan for anxiety, trazadone for insomnia and Zoloft for depression. There was no other analysis for the use of the medications or their effectiveness or how they affected his day to day function. Possible side effects were listed but the CAA did not indicate if he had side effects.
Interview with the MDS representative on 08/30/18 at 5:48 PM revealed nurses analyze and bundle information differently and that he thought there was enough in the CAA.

b. The quarterly MDS dated 08/06/18 coded Resident #44 with having intact cognition, however, section J related to pain indicated he received pain medication and that a resident interview for pain should be completed. The resident interview for pain was not assessed. The staff evaluation for pain was assessed.
Interview with the MDS representative on 08/30/18 at 5:48 PM revealed he could not say why the alert and oriented resident was not interviewed for pain.

5. Resident #43 was admitted to the facility on 07/03/17 with diagnoses of non-Alzheimer's dementia, diabetes, high blood pressure, and anemia.

Review of the annual Minimum Data Set (MDS) dated 07/09/18 revealed section C for the Brief Interview for Mental Status was marked as "Not Assessed" either for the resident interview or the staff assessment.

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An interview conducted on 08/30/18 at 4:50 PM with the Social Worker (SW) revealed he had been employed at the facility since June 2018. He stated he was just recently trained on the MDS sections he was responsible for including section C and began completing those sections at the beginning of August 2018. He stated the Corporate MDS Nurse that trained him told him if the sections were not completed within the time frame to enter "not assessed." The SW further stated that was why section C was marked as not assessed.

An interview with the Administrator on 08/30/18 at 4:56 PM revealed he would have expected the MDS Nurse to complete section C knowing the SW had not been trained and wasn't completing those sections of the MDS at that time.

6. Resident #22 was admitted to the facility on 04/06/18 with diagnoses of hemiplegia, non-Alzheimer's dementia, seizure disorder, and cerebral aneurysm.

Review of the quarterly Minimum Data Set (MDS) dated 07/12/18 revealed section C for the Brief Interview for Mental Status was marked as "Not Assessed" either for the resident interview or the staff assessment.

An interview conducted on 08/30/18 at 4:50 PM with the Social Worker (SW) revealed he had been employed at the facility since June 2018. He stated he was just recently trained on the MDS sections he was responsible for including section C and began completing those sections at the beginning of August 2018. He stated the Corporate MDS Nurse that trained him told him if

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the sections were not completed within the time frame to enter "not assessed." The SW further stated that was why section C was marked as not assessed.

An interview with the Administrator on 08/30/18 at 4:56 PM revealed he would have expected the MDS Nurse to complete section C knowing the SW had not been trained and wasn't completing those sections of the MDS at that time.

7. Resident #29 was admitted to the facility on 05/04/18 with diagnoses of heart failure, hemiplegia, and diabetes.

Review of the quarterly Minimum Data Set (MDS) dated 07/29/18 revealed section C for the Brief Interview for Mental Status was marked as "Not Assessed" either for the resident interview or the staff assessment.

An interview conducted on 08/30/18 at 4:50 PM with the Social Worker (SW) revealed he had been employed at the facility since June 2018. He stated he was just recently trained on the MDS sections he was responsible for including section C and began completing those sections at the beginning of August 2018. He stated the Corporate MDS Nurse that trained him told him if the sections were not completed within the time frame to enter "not assessed." The SW further stated that was why section C was marked as not assessed.

An interview with the Administrator on 08/30/18 at 4:56 PM revealed he would have expected the MDS Nurse to complete section C knowing the SW had not been trained and wasn't completing those sections of the MDS at that time.

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8. Resident #13 was admitted to the facility on 12/27/2012 with diagnosis of chronic osteomyelitis, diabetes, and chronic kidney disease.

Review of the quarterly Minimum Data Set (MDS) dated 07/02/18 revealed sections C for the Brief Interview for Mental Status and D for Mood were marked as "Not Assessed" for neither the resident nor the staff interviews.

An interview conducted on 08/30/18 at 4:50PM with the Social Worker (SW) revealed he had been employed with the facility since June 2018 and had just recently been trained on the MDS sections he would be responsible for which included sections C and D. The SW further added that he had just started completing those sections at the beginning of August 2018. The Corporate MDS Nurse who trained him had directed him to code the sections as "Not Assessed" if they were not completed within the appropriate time frame. The SW further stated that was the reason sections C and D were marked as not assessed.

An interview with the Administrator conducted on 08/30/18 at 4:56PM revealed he would have expected the MDS nurse to complete sections C and D knowing the SW had not been trained and was not completing them.

9. Resident #14 was admitted to the facility on 06/29/18 with diagnosis which included schizoaffective disorder, diabetes, and chronic pain syndrome.

Review of the quarterly Minimum Data Set (MDS) dated 07/03/18 revealed sections C for the Brief

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Interview for Mental Status and D for Mood were marked as "Not Assessed" for neither the resident nor the staff interviews.

An interview conducted on 08/30/18 at 4:50PM with the Social Worker (SW) revealed he had been employed with the facility since June 2018 and had just recently been trained on the MDS sections he would be responsible for which included sections C and D. The SW further added that he had just started completing those sections at the beginning of August 2018. The Corporate MDS Nurse who trained him had directed him to code the sections as "Not Assessed" if they were not completed within the appropriate time frame. The SW further stated that was the reason sections C and D were marked as not assessed.

An interview conducted with the Administrator on 08/30/18 at 4:56PM revealed he would have expected the MDS nurse to complete sections C and D knowing the SW had not been trained and was not completing them.

10. Resident #26 was admitted to the facility on 09/23/13 with diagnosis including coronary artery disease, diabetes, and Alzheimer's Disease.

Review of the annual Minimum Data Set (MDS) dated 07/16/18 revealed section C for the Brief Interview for Mental Status was marked as "Not Assessed" for the resident and staff interviews.

An interview with the Social Worker (SW) conducted on 08/30/18 at 4:50PM revealed he had been employed with the facility since June 2018 and had just recently been trained on the MDS sections he would be responsible for which included section C. The SW further added that he

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had just started completing that section at the beginning of August 2018. The Corporate MDS Nurse who trained him had directed him to code the section as "Not Assessed" if it was not completed within the appropriate time frame. The SW further stated that was the reason section C was marked as not assessed.

An interview conducted on 08/30/18 at 4:56PM revealed he would have expected the MDS nurse to complete section C knowing the SW had not been trained and was not completing it.

11. Resident #33 was admitted to the facility on 09/06/13 with diagnosis of chronic obstructive pulmonary disease, chronic kidney disease, and heart failure.

Review of the annual Minimum Data Set (MDS) dated 07/02/18 revealed sections C for the Brief Interview for Mental Status and D for Mood were marked as "Not Assessed" for neither the resident nor the staff interviews.

An interview conducted on 08/30/18 at 4:50PM revealed he had been employed with the facility since June 2018 and had just recently been trained on the MDS sections he would be responsible for which included sections C and D. The SW further added that he had just started completing sections C and D at the beginning of August 2018. The Corporate MDS Nurse who trained him had directed him to code the sections as "Not Assessed" if they were not completed within the appropriate time frame. The SW further stated that was the reason sections C and D were marked as not assessed.

An interview with the Administrator conducted on

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F 636	Continued From page 26 08/30/18 at 4:56PM revealed he would have expected the MDS nurse to complete sections C and D knowing the SW had not been trained and was not completing them.	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 review and staff interviews the facility failed to accurately code tobacco use and antianxiety medication on Minimum Data Set (MDS) assessments use for 2 of 22 sampled residents (Resident's #38 and #195) reviewed for MDS accuracy. The findings included: 1. Resident #38 was admitted to the facility on 07/30/18 with diagnoses which included Multiple Sclerosis, diabetes, and other fracture. Review of the facility Smoking Assessment dated 08/02/18 revealed Resident #38 was a safe smoker and could smoke independently. Review of the admission Minimum Data Set (MDS) dated 08/06/18 revealed Resident #38 was cognitively intact and current tobacco use was coded as no. An interview conducted on 08/30/18 at 5:28 PM with the Corporate MDS, Director of Reimbursement revealed he reviewed Resident #38's record and stated the 08/06/18 MDS should	F 641	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately coding tobacco use and antianxiety medications. On 9/23/18 resident #38s minimum data set (MDS) assessment dated 8/6/18 was modified to accurately code resident #38 tobacco use of by the MDS consultant. On 9/23/18 resident #195 discharge MDS assessment dated 8/17/18 was modified to accurately code antianxiety medications for resident by the MDS consultant. On 9/24/18 the modified assessments were transmitted to the National Repository by the MDS consultant. On 9/24/18 the modified assessment was accepted by the National Repository. On 9/23/18 the facility consultant began auditing all assessments completed in the past 30 days to ensure residents that use tobacco and/or residents receiving antianxiety medications are coded accurately. Audit will be completed by	9/24/18

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F 641	Continued From page 27 have been coded yes for current tobacco use. An interview conducted on 08/30/18 at 5:35 PM with the Administrator revealed it was his expectation that the MDS be coded correctly. 2. Resident #195 was admitted to the facility on 08/16/18 with diagnoses which included history of falling, general muscle weakness, and bipolar disorder. Review of the medical record for Resident #195 revealed she received antianxiety medication one time during her stay on 08/16/18. Review of the discharge Minimum Data Set (MDS) dated 08/17/18 coded Resident #195 as not receiving antianxiety medication. An interview conducted with the Corporate MDS Representative on 08/30/18 at 5:36PM revealed he reviewed Resident #195's record and stated the discharge MDS dated 08/17/18 should have been coded yes for receiving antianxiety medication. An interview with the Administrator conducted on 08/30/18 at 5:39PM revealed it was his expectation that the MDS would be coded correctly.	F 641	9/23/18. Assessments will be modified for accuracy of coding as necessary. Beginning 9/25/18 the MDS RN, director of nursing, assistant director of nursing, and/or administrator will begin auditing completed and transmitted MDS assessments for correct coding of tobacco use and/or correct coding of antianxiety medications using the accuracy Audit Tool. 5 completed assessments will be audited weekly x 12 weeks. The monthly QI committee will review the results of the accuracy Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The MDS RN is responsible for implementing the acceptable plan of correction. .	
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	F 656		9/23/18

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F 656	Continued From page 28 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 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.	F 656		

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F 656	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for psychotropic medication use for 1 of 5 residents reviewed for unnecessary medication use (Resident #43). The findings included: Resident #43 was admitted to the facility on 07/03/17 with diagnoses of anemia, non-Alzheimer's dementia, and diabetes. Review of the annual Minimum Data Set (MDS) dated 07/09/18 revealed Resident #43 received antipsychotic medication, antianxiety medication, and antidepressant medication during the look back period for the assessment. Review of the Care Area Assessment dated 07/14/18 revealed Psychotropic Drug Use would be addressed in the care plan with a goal that the resident would have minimal side effects from antidepressant and antipsychotic medications. Review of the care plan dated 07/16/18 revealed no psychotropic medication care plan and there were no other notes related to psychotropic medications in any other care plan developed. An interview conducted on 08/30/18 at 5:28 PM with the Corporate MDS, Director of Reimbursement revealed a care plan for psychotropic medication use should have been developed for Resident #43. An interview conducted with the Administrator on 08/30/18 at 5:40 PM revealed it was his	F 656	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately completing a resident□s care plan for psychotropic drug use. A Care Plan were developed for Resident # 43 on 9/23/18 by the facility consultant for the use of psychotropic medications that addresses the use of antipsychotic, antianxiety and antidepressant medications to include a goal and staff interventions. A 100% audit was completed by facility consultant on 9/23/18 for all residents who receive an antipsychotic, antianxiety or antidepressant medication per their last MDS assessment to ensure they have a care plan in place for the use of psychoactive medications. Any negative findings were immediately addressed. The interdisciplinary care plan team was in-serviced by the facility consultant on 9/7/18 to ensure that all residents receiving antipsychotics, antianxiety and/or antidepressant medications are care planned for the use of psychoactive medications.	

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F 656	Continued From page 30 expectation for all resident's taking psychotropic medications to have a care plan.	F 656	The director of nursing, assistant director of nursing, and/or administrator will complete an audit of 5 resident weekly 12 weeks who receive psychotropic medications care plans to ensure psychotropic medication care plans are accurate. This audit will be documented on the care plan audit tool. The Administrator will review the care plan audit tools with the QI Committee monthly for 6 months for follow up and recommendations or continuation as indicated. The director of nursing is responsible for implementing the acceptable plan of correction	
F 689 SS=J	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, resident interview, staff interview, and physician interview, the facility failed to put an effective plan in place to prevent 1 of 4 sampled residents who smoked from smoking inside the building (Resident #44) which placed Resident #44 and all the other	F 689	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to deficiency failure to put an effective plan into place to prevent resident who smoked from smoking in the building- was staff failure to follow care	8/31/18

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F 689	Continued From page 31 residents in the facility at risk of the facility catching on fire. Immediate Jeopardy began on 03/08/18 when Resident #44 was caught a second time smoking in his room. Nursing notes revealed Resident #44 continued to exhibit evidence of smoking in the facility via smoke smells and to have smoking materials on his person. Immediate Jeopardy was removed on 08/30/18 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to supervision to prevent accidents. The findings included: Review of the facility's Smoking Policy with a revision date of 02/01/18 included the following: *Smoking is not allowed inside of this facility, under any circumstances, at any time. *All resident smoking materials are maintained in a secured area and are accessible only through the assistance of the facility's staff. *When the Smoking Evaluation identifies a resident with any potential hazard risk, the resident will be allowed to smoke only during this facility's designated smoking times with direct staff supervision. Resident #44 was originally admitted to the facility on 03/13/15. His diagnoses included Alzheimer's Disease, orthostatic hypotension, dysphagia, and end stage renal disease (requiring dialysis).	F 689	plan interventions due to communication and knowledge deficit. The plan started on August 13, 2018 because incidents related to potential smoking in non-designated areas for resident #44 were addressed with interventions, that were then tapered based on resident behavior. On August 13, 2018, Resident #44 was found by nurse where there were 6 cigarette butts found in residents bathroom. Resident #44 has history of non-compliance with smoking which care plan was developed on March 24, 2016 but facility failed to follow care plan to ensure that resident did not have smoking materials, due to staff knowledge deficit. When Resident #44 was found with cigarette butts reeducation was not done until August 24, 2018. Re-education of resident provided by facility has not been effective long term for resident # 44, despite a 15 BIM score, because of resident making poor and non-compliant choices. During the investigation the root cause of non-compliance was identified that reeducation of Resident #44 was not done promptly and care plan was not updated promptly post event to prevent reoccurrence. On 8/6/18 resident # 44 was assessed to have a BIMS of 15. On 8/13/18 resident # 44 was found by nurse with 6 cigarette butts. On 8/24/18 resident # 44 was re-educate by ADON on the smoking policy. On 8/28/18 approximately 5pm resident	

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Resident #44's annual Minimum Data Set (MDS) dated 02/12/18 coded him with having intact cognition, and requiring supervision only for activities of daily living skills including ambulation.

A Smoking Evaluation dated 03/01/18 noted he did not deposit lit items correctly in the ashtray. The outcome was that he was a safe smoker and may smoke independently.

A care plan was developed on 03/01/18 noting he could smoke independently. The resident acknowledged the rules and criteria related to smoking and was able to demonstrate safe smoking. The care plan was updated 03/02/18 indicating he needed to be supervised related to noncompliance with the rules.

A Social Progress note dated 03/03/18 at 10:14 AM, stated that "Due to unsafe behavior in room, resident is now a supervised smoker and MUST turn in cigarettes when returning in the building." Social notes dated 03/03/18 at 10:15 AM, stated the resident understood his supervised smoking status.

Nursing notes dated 03/05/18 at 11:57 AM stated the resident was assessed and is a supervised smoker due to a change in mental status and behaviors. The resident was aware of status change and smoking times.

The smoking care plan was updated 03/05/18 which indicated he needed to be supervised while smoking due to noncompliance. He was to check in with staff every time he returns from Dialysis and give up his smoking items.

F 689

#44□s bathroom was noted to have faint smell of cigarette smoke. Resident #44□s room was not noted to have visible smoke, and resident denied smoking. Resident #44 was noted with a partially smoked cigarette butt in top shirt pocket, no lighter upon facility staff check after faint smell noted.
On 8/28/18 at approximately 515pm resident # 44 was placed on 1 to 1 smoking supervision by facility. This intervention was put into place to decrease risk resident would gather smoking materials such as cigarette butts during designated smoke times and bring back into facility.
On 8/29/18 resident #44 was placed on 1 to 1 supervision when in facility to prevent smoking in unauthorized locations. This intervention will continue as long as resident resides in facility.
On 8/29/18 resident #44□s pockets were checked by facility staff after dialysis for smoking materials. No smoking materials found in resident clothing.
On 8/30/18 resident # 44 was seen by psychiatric nurse practioner (PNP) in the facility for behaviors including smoking in undesignated areas. On 8/29/18 and 8/30/18 resident #44□s care plan related to smoking, including non-compliance, was reviewed and updated by the DON, ADON, administrator, and corporate consultant team. PNP did not order a level of care change for resident during visit. Resident is followed by PNP with visits every 3 months and as needed.
On 8/29/18 and 8/30/18 resident #44□s care plan related to smoking, including

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A Social Progress note dated 03/08/18 at 10:09 AM stated "Social worker was informed of caught smoking in his room again. Social worker spoke with resident. He stated he did not remember smoking again, but when social worker mentioned staff and the smoke, he nodded. Social worker confiscated cigarettes and temporarily terminated resident's smoking privileges. Will reevaluate in a month."

Progress notes revealed the following related to Resident #44's smoking:

*03/10/18 at 7:35 AM nursing note: "Room smelled of smoke, said he was not smoking in room."
*03/10/18 at 7:10 PM nursing note: "Room smelled of smoke. No cigarettes observed. No lighter in presence of resident. Resident denies any smoking. DON (Director of Nursing) aware. SW (social worker) area (sic for aware). Resident's door is open and nursing staff watching closely. Will continue to monitor."
*03/12/18 at 12:24 PM social note: "Upon safety search of resident's room, two unsmoked cigarettes were found along with a smoked one. They are in the social worker's office."
*03/13/18 at 8:50 AM nursing note: The Administrator and DON discussed with the resident the importance of not smoking in his room and going out for supervised smoke breaks. Informed him if he smoked again he was subject to receive a 30 day discharge notice. He acknowledged understanding.
*03/15/18 at 11:30 AM interdisciplinary meeting with resident present: Resident stated that he gets cigarettes and lighter from dialysis. Staff spoke of hazards and the oxygen room being 2 doors down and there are 50 canisters of oxygen

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non-compliance, was reviewed and updated by the DON, ADON, administrator, and corporate consultant team with intervention for 1 to 1 supervision, this intervention will not resolve until resident no longer resides in facility. Interventions are specific to resident and behavior including ensuring smoking materials secure upon return from dialysis and 1 to 1. Resident was educated on several occasions and is in agreement with plan as evidenced by conversation with administrator on 8/30/18. The group activity log proves resident participates in group activities including Bingo and church services.
On 8/29/18 the ADON began an in-service with all staff on resident #44s interventions, resident to be checked upon return from appointment, 1 to 1 supervision for smoking, 1 to 1 supervision, resident to be checked when returns from smoke break, to ensure safety related to smoking. No staff will be allowed to work after 8/30/18 until in-service has been completed. This in-service will be part of the orientation for newly hired staff.
On 8/30/18 resident #44 was provided with re-education by administrator on the smoking policy, including scheduled smoking times, location of smoking area, consequences for not following policy including discharge. Resident verbalized education back to administrator.
On 8/30/18 resident #44 was moved to different room, which is in closer proximity to a nurse□s station for supervision, and with no window in bathroom.

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at any given time. Resident agreed to turn in smoking materials when returning from dialysis. Resident will receive 2 cigarettes at dialysis and lighter. If caught one more time, a 30 day discharge will be issues. Resident and sister in agreement.
*04/13/18 at 10:52 AM social note: Social worker notified sister of behavior last night (previous note was 04/11/18 with no behaviors documented) and smoking in the room. Sister has been notified of 30 day discharge notice.
*04/13/18 at 6:30 PM nursing note: "Resident returned from Dialysis and was asked if he had cigarettes and a lighter and resident stated, 'No'. About ten minutes later resident exited bedroom and smelled of smoke. Nurse immediately went into patient's room and the room had a fog in it and smelled of cigarette smoke. When nurse asked resident, resident denied smoking or having smoking tools. Nurse observed resident hid lighter in his hand. Resident refused to give lighter to nurse. Cigarette butts were found in trashcan in bedroom. Resident finally gave nurse red lighter. Nurse educated resident on the importance of not smoking and following safety guidelines. Resident laughed at nurse. 1 on 1 supervision was immediately initiated.

Interview with the Administrator on 08/30/18 at 9:32 AM revealed he found information regarding the 04/13/18 incident from the previous administration which indicated Resident #44's 1 on 1 supervision lasted 5 days.

On 04/20/18 at 7:01 PM nursing notes stated Resident returned from dialysis at 5:00 PM. No cigarettes on resident. Resident did have a lighter in his pocket and it was locked in the med room.

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On 8/30/18 resident #44□s belongings were checked for smoking paraphernalia by administrator with none noted. Beginning 8/31/18 facility will send a staff member to dialysis with resident #44 to provide supervision prior to and after each treatment and during transportation. The staff member that will supervising resident will be provided with the all staff in-service and will be in addition to the contracted transportation service driver. This will provide additional supervision to reduce the potential of resident concealing smoking paraphernalia when on appointment. This intervention will continue as long as resident resides in facility.

On 8/28/18 the corporate facility consultant audited all resident rooms for smoking paraphernalia. No additional negative findings noted.

On 8/29/18 the administrator and DON completed an audit of all resident rooms, including resident #44□s room, for smoking paraphernalia with no negative findings.

On 8/30/18 the facility staff completed an audit of all resident rooms, including resident #44□s room, for smoking paraphernalia with no negative findings.

In-servicing:
1. On 8/29/18 the assistant director of nursing (ADON) began an in-service with licensed nursing staff on independent

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F 689	Continued From page 35 Interview with the Ombudsman on 08/30/18 at 12:06 PM revealed that she went to the facility after receiving a phone call from Resident #44's sister who expressed concern about the discharge related to if he would be in a facility close to her and still be able to get dialysis. The Ombudsman stated that upon her arrival the previous administrator followed her into Resident #44's room and announced that she was rescinding the discharge notice due to no placement was found for the resident and there was inappropriate documentation of the discharge issues. The Ombudsman stated she only provided family and administration technical education on ensuring a safe discharge. Resident #44 had a quarterly MDS dated 05/09/18 which coded him with intact cognition and requiring supervision for all activities of daily living including ambulation. He was coded with no behaviors. Progress notes related to Resident #44 smoking continue: *Nursing notes dated 05/13/18 at 2:40 AM revealed "Smoke was smelled dowm (sic) adm. (administrative) hall. Resident came through double door. Strong odor of smoke smelled. Resident came down to room. When questioned about smoking down there, resident deny. (name of administrator) called. Resident was checked good for cigarettes and lighter. Found 2 butts wrapped in tissue paper. No lighter found. Resident said he had not been smoking or had lighter. Resident on 15 min. (minute) checks. Reminded resident he is not to go through double doors." *Nursing notes dated 05/22/18 at 8:44 PM	F 689	smokers, including they must return smoking materials when return in facility. This in-service will be completed by 8/30/18. After 8/30/18 no licensed nurse will be allowed to work until in-service is complete. This in-service will be part of the orientation for newly hired licensed nurses. 2. On 8/29/18 the ADON began an in-service with all staff on resident #44s interventions to ensure safety related to smoking. No staff will be allowed to work after 8/30/18 until in-service has been completed. This in-service will be part of the orientation for newly hired staff. 3. On 8/30/18 all staff will be in-serviced by the ADON 1 on 1. Resident must be supervised to prevent incidents and accidents, including smoking, 2. If a resident has a concern related to safety you must intervene immediately, this includes smoking. 3. Notify DON and administrator of any residents smoking or suspected of smoking in their room or any undesignated area and place resident on 1 to 1 supervision until further instructions are received by DON/Administrator. This in-service will be completed on 8/30/18. No staff will be allowed to work after 8/30/18 until in-service complete. Starting 8/30/18, no staff will be permitted to work until education is received and post-test is administered. On 8/31/18, any staff not in-serviced will be mailed via USPS certified mail a copy of the in-services and a post test. The employee will not be allowed to work until this education, including post-test is complete. Compliance will be ensured and tracked	

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F 689	Continued From page 36 revealed the resident was in bathroom of his room and cigarette smoke smell was noted. Resident #44 denied smoking. The nurse asked him again and Resident #44 admitted to smoking in his bathroom. Upon administrative direction, Resident #44 was checked and one pink lighter was found. The plan was for Resident #44 to be placed on 15 minute checks and if he goes out to smoke staff is to do 1 on 1 supervision with him while he is smoking. *Nursing notes dated 05/30/18 at 9:06 PM, written by Nurse #4, stated the nurse went into his room and cigarette butts were on his bed. Located resident in the main hall and asked him if he had any cigarette butts and he said no. When told of finding the 3 cigarette butts and showed them to him he cursed. He was re-educated on the smoking policy. *Nursing notes dated 06/02/18 at 3:27 AM, written by Nurse #5, stated the 7P-7A charge nurse reported to this writer that nurse aide had turned in 6 cigarette butts and one green lighter which was retrieved from the resident after he had been to the 8 PM smoke break. Nurse aide reported he was provided 1 on 1 observations while he was smoking. *Nursing notes dated 06/02/18 at 11:25 AM, written by Nurse #3, revealed the central hall charge nurse checked the resident after the 11 AM smoke break and he was found to have 2 cigarette butts in his front pocket. Follow up nursing note dated 06/02/18 at 11:31 AM revealed the nurse verified he was provided 1 on 1 supervision during that smoke break. *Social note dated 06/04/18 at 4:49 PM stated resident allowed the social worker to check him upon return from dialysis. Only red lighter found and put in smoke box. *Nursing note dated 06/09/18 at 11:29 AM stated	F 689	by the DON, and ADON. The director of nursing (DON), ADON, and/or administrator will review 50% of residents rooms weekly x 12 weeks to ensure no smoking paraphernalia is present in room. Based on the smoking policy all resident smoking materials are maintained in a secured area and are accessible only through the assistance of the facility s staff. This audit will be documented on the resident room audit tool. The DON, ADON, administrator, social worker, and/or licensed nurse will audit once daily seven times per week x 12 weeks to include weekends, and varying times to ensure scheduled supervised smoking times are supervised by facility staff as designated by residents care plans. This audit will be documented on the smoking audit tool. 1 to 1 supervision, including during dialysis appointments will be verified 5 times weekly by the administrator and/or DON using the documentation log. This audit will continue until resident no longer resides in facility. The DON, ADON, administrator, and or licensed nurse will audit resident #44s room daily 7 times weekly x2 weeks, then 5 times weekly x 10 weeks for smoking paraphernalia. This audit will be documented on a room check audit tool. The monthly QI committee will review the results of the resident room audit tool and room check audit tool for 3 months for identification of trends, actions taken, and	

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staff went into resident's room and it smelled like cigarette smoke. Staff checked room and found beer cans and a liquor bottle. Nurse called DON and Administrator.

A Smoking Evaluation for Resident #44 dated 06/11/18 noted that he smoked in areas other than the designated smoking area and he was assessed as an unsafe smoker and required direct supervision while smoking.

Nursing notes dated 07/01/18 at 11:00 PM, written by Nurse #4, stated the nurse aide reported resident was smoking in his bathroom. The nurse knocked on the bathroom door and informed the resident it was the nurse. The resident had the door cracked open and nurse saw the resident with his head in raised window and bathroom smelled of smoke. Resident was reeducated on smoking in the facility. Nurse aide had found 3 cigarette butts in his room.

Resident #44 was again assessed as requiring supervision while smoking per his Smoking Evaluation dated 07/11/18 for smoking outside designated areas.

The quarterly MDS dated 08/06/18 coded Resident #44 has having intact cognition, no behaviors and requiring supervision with all activities of day living skills.

Nursing notes dated 08/06/18 at 8:35 PM, written by Nurse #4, revealed the nurse aide and first shift nurse reported a strong smoke smell in the resident's bathroom. With the window up. The nurse aide found 2 cigarette butts and a whole cigarette. The resident was re-educated about smoking policy.

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to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The Quarterly QAPI Committee met, including medical director, on 8/30/18 at 145pm and reviewed resident #44□s smoking and safety interventions; and the credible allegation for supervision to prevent accident and incidents.

The administrator and DON will be responsible for the implementation of the plan to ensure the facility provides supervision to prevent accidents and incidents, including related to smoking. Corporate oversight will be provided by the corporate regional vice president (RVP), and or the facility consultant by onsite or offsite reviews to ensure the administrator and DON implements and monitors the plan of correction. Immediate jeopardy was removed on 8/30/18.

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Nursing notes dated 08/13/18 at 9:58 PM written by Nurse #3, revealed resident was smoking in the bathroom of his room. Found 6 cigarette butts in his bathroom and one in the toilet. Asked how he lit it and he responded saying he rubbed 2 sticks together. This nurse asked for the lighter and he would not give it up. Checked his pockets and no lighter was found.

Nurse #3, who wrote the 8/13/18 nursing note was interviewed via phone on 08/29/18 at 8:30 PM. Nurse #3 stated she smelled smoke and found Resident #44 in the bathroom. He denied smoking but cigarette butts including one in the toilet were found. She stated she did not check him thoroughly for smoking materials although she thought about it. She could not give a reason why she did not check him. She reported it to the Assistant Director of Nursing (ADON). Nurse #3 stated that Resident #44 was permitted to take 2 cigarettes with him to dialysis.

Nursing notes dated 08/24/18 at 2:51 PM revealed the resident was educated that he was expected to abide by the smoking policy. Resident understands the policy and signed the policy and stated he will follow the policy.

On 08/28/18 at 5:46 PM Nurse Aide (NA) #1 stated she had never caught Resident #44 smoking but had smelled smoke in his room before. She stated each time staff smell smoke, they check Resident #44 for lighters and cigarettes.

Observations on 08/28/18 at 5:47 PM revealed Resident #44's room had an odor from smoke coming from the bathroom he was using. His

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room was located at the very end of the hall and had a connecting bathroom to the room next door. In the adjacent room resided Resident #40 who had an oxygen tank at bedside. On 08/28/18 at 5:49 PM Resident #44 was observed walking down the hall.

On 08/28/18 at 5:51 PM Nurse #1 stated she had never caught Resident #44 smoking in his room but suspected he smoked in the building due to the smell of cigarette smoke. Nurse #1 accompanied the surveyor to Resident #44's bathroom and confirmed she smelled smoke. She further stated that last week Resident #44 was suspected of smoking in his room and his roommate was moved out of his room since his roommate used oxygen. She further stated that Resident #44 was checked for smoking materials after each dialysis trip. She said last week he had a lighter and cigarette in his belt upon his return from dialysis.

The Administrator stated on 08/28/18 at 6:00 PM that Resident #44 signed an agreement to be checked for smoking materials after dialysis. The Administrator stated that still Resident #44 is able to hide smoking materials. Resident #44 had been seen throwing cigarettes out of the window when staff are coming near. The facility has completed a new FL2 form on which his level of care was changed from needing skilled care to assisted living. The social worker is looking for placement.

On 08/28/18 at 6:07 PM the Administrator and Nurse #2 with the surveyors went to check Resident #44 for smoking materials. The only thing found was a cigarette butt in his front pocket. When Resident #44 was asked about

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smoking in the building, he stated he did not do so this date. When asked about being caught last week he did not admit or deny smoking in the facility. At this time Resident #44 was able to say he was not to smoke in the facility for the safety of the other residents.

The Administrator stated during interview on 08/28/18 at 6:15 PM that either the receptionist or the nurse checked Resident #44 for smoking materials each time he returned from dialysis. In the past they tried 1 on 1 smoking with him so that staff could provide attention only to Resident #44 while smoking and not watch the whole group at one time. He stated the resident has been observed picking cigarette butts off the ground. The Administrator stated he was reconsidering 1 on 1 smoking for Resident #44 again. The Administrator was unable to say why the discharge in April was never completed as it was before he was the administrator.

The Director of Nursing stated during interview on 08/29/18 at 2:30 PM that someone has to walk Resident #44 from the door to his room after he returns from dialysis to check for smoking materials. She stated checking Resdient #44 after dialysis was implemented approximately a month ago. She stated that a week ago a nurse aide checked him following dialysis and later he was found to have smoking materials in his waist band. At that time his roommate who used oxygen was moved to a different room. She had not thought of Resident #40, who was in the adjacent bedroom that shared the bathroom with Resident #44, having oxygen in use also.

The Administrator stated on 08/30/18 at 9:32 AM that he started working in the facility in June

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F 689	Continued From page 41 2018. During his time at the facility he stated that if staff placed Resident #44 on 1 to 1 supervision or 15 minute checks, that supervision only lasted 24 hours if he was not found violating the smoking rules. He stated the 1 on 1 supervision was only provided while Resident #44 was taken to smoke. The Administrator was unable to provide documentation related to this supervision. The ADON was interviewed on 08/30/18 at 10:47 AM. She stated she was informed about the smoke in the hall that was documented on 08/13/18. She stated that dialysis lets him do anything he wants to do while there and the facility sends him with 2 cigarettes but no lighter to dialysis. ADON stated that once the smoke was reported on 08/13/18 she did not search him for smoking materials. She stated when she was a nurse on the floor she would search him. ADON stated Resident #44 was very noncompliant and would not listen to instructions. Nurse #4 was interviewed on 08/30/18 at 11:06 AM. She stated Resident #44 had been caught smoking in the facility over a year ago. She stated that more recently housekeepers had reported seeing him blow smoke from his bathroom window when he resided in a different room. She stated she has checked for smoking materials and would sometimes find them in his closet, waist band, etc. She described him as very fast when getting cigarette butts from the outdoor ashtrays. She stated he has been known to leave the dialysis center and go to the store for cigarettes and beer. Resident #44's physician was interviewed on 08/30/18 at 12:55 PM. He stated he has been kept informed of Resident #44's noncompliance	F 689		

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with the smoking policy. He stated that Resident #44 is not truthful, knows what he is doing, and tries to cheat the system. He stated the facility has searched him and doing what they can to keep him compliant.

The Administrator was informed of Immediate Jeopardy on 08/30/18 at 11:33 AM.

On 08/30/18 at 6:04 PM, the facility provided the following Credible Allegation of Immediate Jeopardy removal:

* Plan of correcting the specific deficiency:
The plan started on August 13, 2018 because incidents related to potential smoking in non-designated areas for resident #44 were addressed with interventions, that were then tapered based on resident behavior.
On August 13, 2018, Resident #44 was found by nurse where there were 6 cigarette butts found in residents bathroom. Resident #44 has history of non-compliance with smoking which care plan was developed on March 24, 2016 but facility failed to follow care plan to ensure that resident did not have smoking materials, due to staff knowledge deficit. When Resident #44 was found with cigarette butts reeducation was not done until August 24, 2018. Re-education of resident provided by facility has not been effective long term for resident # 44, despite a 15 BIM score, because of resident making poor and non-compliant choices.
During the investigation the root cause of non-compliance was identified that reeducation of Resident #44 was not done promptly and care plan was not updated promptly post event to prevent reoccurrence.
On 8/6/18 resident # 44 was assessed to have a

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F 689	Continued From page 43 BIMS of 15. On 8/13/18 resident # 44 was found by nurse with 6 cigarette butts. On 8/24/18 resident # 44 was re-educate by ADON on the smoking policy. On 8/28/18 approximately 5pm resident #44's bathroom was noted to have faint smell of cigarette smoke. Resident #44's room was not noted to have visible smoke, and resident denied smoking. Resident #44 was noted with a partially smoked cigarette butt in top shirt pocket, no lighter upon facility staff check after faint smell noted. On 8/28/18 at approximately 5:15pm resident # 44 was placed on 1 to 1 smoking supervision by facility. This intervention was put into place to decrease risk resident would gather smoking materials such as cigarette butts during designated smoke times and bring back into facility. On 8/29/18 resident #44 was placed on 1 to 1 supervision when in facility to prevent smoking in unauthorized locations. This intervention will continue as long as resident resides in facility. On 8/29/18 resident #44's pockets were checked by facility staff after dialysis for smoking materials. No smoking materials found in resident clothing. On 8/30/18 resident # 44 was seen by psychiatric nurse practioner (PNP) in the facility for behaviors including smoking in undesignated areas. On 8/29/18 and 8/30/18 resident #44's care plan related to smoking, including non-compliance, was reviewed and updated by the DON, ADON, administrator, and corporate consultant team. PNP did not order a level of care change for resident during visit. Resident is followed by PNP with visits every 3 months and as needed. On 8/29/18 and 8/30/18 resident #44's care plan	F 689		

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(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 689	Continued From page 44 related to smoking, including non-compliance, was reviewed and updated by the DON, ADON, administrator, and corporate consultant team with intervention for 1 to 1 supervision, this intervention will not resolve until resident no longer resides in facility. Interventions are specific to resident and behavior including ensuring smoking materials secure upon return from dialysis and 1 to 1. Resident was educated on several occasions and is in agreement with plan as evidenced by conversation with administrator on 8/30/18. The group activity log proves resident participates in group activities including Bingo and church services. On 8/29/18 the ADON began an in-service with all staff on resident #44s interventions, resident to be checked upon return from appointment, 1 to 1 supervision for smoking, 1 to 1 supervision, resident to be checked when returns from smoke break, to ensure safety related to smoking. No staff will be allowed to work after 8/30/18 until in-service has been completed. This in-service will be part of the orientation for newly hired staff. On 8/30/18 resident #44 was provided with re-education by administrator on the smoking policy, including scheduled smoking times, location of smoking area, consequences for not following policy including discharge. Resident verbalized education back to administrator. On 8/30/18 resident #44 was moved to different room, which is in closer proximity to a nurse's station for supervision, and with no window in bathroom. On 8/30/18 resident #44's belongings were checked for smoking paraphernalia by administrator with none noted. Beginning 8/31/18 facility will send a staff member to dialysis with resident #44 to provide supervision prior to and after each treatment and	F 689		

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during transportation. The staff member that will supervising resident will be provided with the all staff in-service and will be in addition to the contracted transportation service driver. This will provide additional supervision to reduce the potential of resident concealing smoking paraphernalia when on appointment. This intervention will continue as long as resident resides in facility.

*The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
On 8/28/18 the corporate facility consultant audited all resident rooms for smoking paraphernalia. No additional negative findings noted.

On 8/29/18 the administrator and DON completed an audit of all resident rooms, including resident #44's room, for smoking paraphernalia with no negative findings.

On 8/30/18 the facility staff completed an audit of all resident rooms, including resident #44's room, for smoking paraphernalia with no negative findings.

*In-servicing:
1. On 8/29/18 the assistant director of nursing (ADON) began an in-service with licensed nursing staff on independent smokers, including they must return smoking materials when return in facility. This in-service will be completed by 8/30/18. After 8/30/18 no licensed nurse will be allowed to work until in-service is complete. This in-service will be part of the orientation for newly hired licensed nurses.
2. On 8/29/18 the ADON began an in-service with all staff on resident #44s interventions to

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ensure safety related to smoking. No staff will be allowed to work after 8/30/18 until in-service has been completed. This in-service will be part of the orientation for newly hired staff.
3. On 8/30/18 all staff will be in-serviced by the ADON on 1. Resident must be supervised to prevent incidents and accidents, including smoking, 2. If a resident has a concern related to safety you must intervene immediately, this includes smoking. 3. Notify Don and administrator of any residents smoking or suspected of smoking in their room or any undesignated area and place resident on 1 to 1 supervision until further instructions are received by DON/Administrator. This in-service will be completed on 8/30/18. No staff will be allowed to work after 8/30/18 until in-service complete. Starting 8/30/18, no staff will be permitted to work until education is received and post-test is administered. On 8/31/18, any staff not in-serviced will be mailed via USPS certified mail a copy of the in-services and a post test. The employee will not be allowed to work until this education, including post-test is complete. Compliance will be ensured and tracked by the DON, and ADON.

*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:

The director of nursing (DON), ADON, and/or administrator will review 50% of residents' rooms weekly x 12 weeks to ensure no smoking paraphernalia is present in room. Based on the smoking policy "all resident smoking materials are maintained in a secured area and are accessible only through the assistance of the

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facility's staff." This audit will be documented on the resident room audit tool.
The DON, ADON, administrator, social worker, and/or licensed nurse will audit once daily seven times per week x 12 weeks to include weekends, and varying times to ensure scheduled supervised smoking times are supervised by facility staff as designated by residents' care plans. This audit will be documented on the smoking audit tool.
1 to 1 supervision, including during dialysis appointments will be verified 5 times weekly by the administrator and/or DON using the documentation log. This audit will continue until resident no longer resident no longer resides in facility.
The DON, ADON, administrator, and or licensed nurse will audit resident #44s room daily 7 times weekly x2 weeks, then 5 times weekly x 10 weeks for smoking paraphernalia. This audit will be documented on a room check audit tool.

The monthly QI committee will review the results of the resident room audit tool and room check audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The Quarterly QAPI Committee met, including medical director, on 8/30/18 at 145pm and reviewed resident #44's smoking and safety interventions; and the credible allegation for supervision to prevent accident and incidents.

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F 689	Continued From page 48 *The title of the person responsible for implementing the acceptable plan of correction: The administrator and DON will be responsible for the implementation of the plan to ensure the facility provides supervision to prevent accidents and incidents, including related to smoking. Corporate oversight will be provided by the corporate regional vice president (RVP), and or the facility consultant by onsite or offsite reviews to ensure the administrator and DON implements and monitors the plan of correction. Immediate Jeopardy was removed on 08/30/18 at 7:40 PM when interviews with direct care and supervisory staff from all 3 shifts confirmed they had been inserviced on the policy and procedures for smoking, including who could smoke independently and how smoking materials were managed for those residents requiring supervision. In addition staff were aware of the specific needs of Resident #44 including the 1 on 1 supervision at all times. Observations revealed Resident #44 was under 1 on 1 supervision and his room had been changed to be closer to the nursing station. Resident #44's care plan had been updated, as well as other residents who smoked. The facility remains out of compliance at a lower scope and severity.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		9/24/18

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F 761	Continued From page 49 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications ready for use from 1 of 2 medication carts (Central Hall). The findings included: An observation made on 08/30/18 at 3:35 PM of the Central Hall medication cart revealed the following expired medications: Allopurinol 100 milligrams, 24 tabs with an expiration date of 03/27/18 Ativan 0.5 milligrams, 2 cards of 30 tabs each with an expiration date of 08/11/18. Ultram 50 milligrams, 6 tabs with an expiration date of 08/16/18	F 761	The position of Magnolia Lane Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to remove expired medications from use- was the staff failure to follow policies for medication storage due to knowledge deficit. On 8/30/18 the Director of Nursing (DON) removed 24 tablets of allopurinol 100mg tablets, 60 tablets of Ativan 0.5mg tablets, and 6 tablets of Ultram 50 mg tablets. Medications were discarded per pharmacy policy. On 9/4/18 the DON audited all medication carts to ensure all medications were in	

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F 761	Continued From page 50 An interview conducted with Nurse #1 on 08/30/18 at 3:40 PM revealed the pharmacy checked the medication carts for expired medications but it was also her responsibility to check the expiration dates of all medications in her cart. She stated she had not checked her medication cart for expired medications today. An interview conducted on 08/30/18 at 3:41 PM with the Director of Nursing revealed it was her expectation for all nurses to check their medication carts for expired medications daily. She stated the expired medications should have been removed from the cart on their expiration dates.	F 761	date and stored according to the medication storage policy. Findings include: Expired Saline spray, artificial tears, eye drops. All were removed immediately and discarded per pharmacy policy. On 9/6/18 an in-service was started by the assistant director of nursing (ADON) on removal disposal of expired medications per facility policy for all licensed nurses, and medication aides. This in-service will be complete by 9/24/18. No licensed nurses, or medication aides will be allowed to work after 9/24/18 until in-service completed. This in-service will be included with orientation for all newly hired licensed nursing staff, and medication aides. The director of nursing, and/or designee, will audit 50% of medication carts weekly x 12 weeks to ensure no expired medications are present. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations	

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F 761	Continued From page 51	F 761	and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction. .	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 09/08/17. This was for deficiencies recited during a recertification and complaint survey of 08/30/18 in the areas of F 641 Accuracy of Minimum Data Set (MDS) Assessments and F 656 Development of Comprehensive Care Plans. The continued failure of the facility during two federal surveys of record shows a pattern of the facility to sustain an effective QAA program. The findings included: This citation is cross referenced to:	F 867	The position of Magnolia Lane Nursing and Rehabilitation Center regarding the process that led to this deficiency was failure to follow established facility policy and protocols. On 9/20/2018, the facility held an Executive QI Committee meeting. The Medical Director, Administrator, Director of Nursing, Social Worker, MDS nurse, Staff Facilitator, Maintenance Director, Activity Director and Housekeeping Supervisor will attend Executive QI Committee meetings on an on-going basis and will assign additional team members as appropriate. On 9/5/18, the corporate facility consultant in-serviced the Administrator. On 9/6/2018	9/20/18

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1. F 641- Accuracy of Assessments. Based on record review and staff interviews the facility failed to accurately code tobacco use and antianxiety medication use on the Minimum Data Set (MDS) assessments for 2 of 22 sampled residents (Resident #38 and #195).

During a recertification survey on September 08, 2017 the facility was cited for failure to accurately assess 2 of 30 sampled residents for toileting abilities. The residents' toileting abilities were coded as not having occurred during their assessments.

During an interview with the Administrator on 08/30/18 at 7:49PM he stated the biggest issue that had lead to a failure in the Quality Assurance system was no full time in-house MDS Coordinator due to turn over in that position with the current MDS Coordinator having been employed with the facility only since June 2018.

2. F 656- Development of care plans: Based on record review and staff interviews, the facility failed to develop a care plan for psychotropic medication use for 1 of 5 residents reviewed for unnecessary medication use (Resident #43).

During a recertification survey on September 08, 2017 the facility was cited for failure to develop a comprehensive care plan which included specific and individualized approaches for 3 of 3 residents at risk for weight loss and 1 of 1 resident reviewed for discharge planning.

During an interview with the Administrator on 08/30/18 at 7:49PM he stated the biggest issue that had lead to a failure in the Quality Assurance system was no full time in-house MDS

F 867

the Administrator in-serviced the Director of Nursing, Social Worker/Admissions Coordinator, Maintenance Director, Staff Facilitator, Activity Director, Dietary Manager, Housekeeping Supervisor, and Rehab Manager regarding the appropriate functioning of the QI Committee and the purpose of the committee to include the identification of issues related to F641-Accuracy of MDS Assessments and F656-Development of Care Plans.

As of 9/20/18, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of audit tools, review of Point Click Care (Electronic Medical Record), pharmacy reports and regional facility consultant recommendations.

The facility QI Committee will meet monthly to identify issues related to quality assessment and assurance activities as needed will develop and implement appropriate plans of action for identified facility concerns.

The QI Committee will continue to meet monthly with oversight by a corporate consultant. The QI Committee meeting agenda and minutes with resulting plans of corrections and audit results will be reviewed as a component of this oversight after each QI Committee meeting.

The Executive QI Committee, including the Medical Director, will review monthly

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F 867	Continued From page 53 Coordinator due to turn over in that position with the current MDS Coordinator having been employed with the facility only since June 2018.	F 867	compiled QI report information, review of trends and review of corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator or designee will report back to the Executive QI Committee at the next scheduled meeting. The person responsible for implementation of this plan is the administrator.	