STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345156	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HALL NURSING AND REHABILITATION CENTER	312 WARREN AVENUE KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/27/24 through 10/30/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 5F3S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/27/24 through 10/30/24. Event ID# 5F3S11. The following intakes were investigated NC00221331, NC00218158, NC00219827, NC00221106, NC00210554, NC00221421, NC00213759, NC00223048, and NC00219634. 3 of the 19 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident interview and staff interviews, the facility failed to assess the ability of a resident to self-administer medications prior to leaving the resident's medications on the bedside table in the resident's room for 2 of 2 residents observed with medications at bedside (Resident #25 and Resident #62). Findings included:	F 554	F554 Resident Self Admin Meds-Clinically Appropriate On 10/28/24, the Director of Nursing immediately verbally educated nurse #3 on ensuring resident takes medications as prescribed and not leaving medications at resident bedside unless a Self-Administration of Medications assessment has been completed and physician order obtained for resident to	11/13/24

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

Electronically Signed | 11/08/2024

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F 554	Continued From page 1	F 554		

1. Resident #25 was admitted to the facility on 5/1/23.

Resident #25's quarterly Minimum Data Set Assessment (MDS) dated 7/23/24 indicated Resident #25 was cognitively intact.

Physician orders included the following medication orders for Resident #25 that were active on 10/28/24:
- Atorvastatin Calcium Tablet 40 milligram (mg) tablet give one tablet one time a day for supplement
- Gabapentin Oral Capsule 100 mg tablet give one tablet one time a day for pain
- Metoprolol Succinate ER 50 mg tablet give one tablet one time a day for hypertension
- Sertraline HCL oral 150 mg tablet give one tablet one time a day for depression
- Amoxicillin-Pot Clavulanate 875-125 mg tablet give one tablet every 12 hours for bacterial infection
-Doxycycline Hyclate Oral 100 mg capsule give one capsule two times a day for infection

There was no documentation in the Electronic Medical Record (EMR) that Resident #25 had been assessed to self-administer his medications. There was no physician's order for self-administration, and there was no care plan that addressed self-administration of medication.

On 10/28/24 at 9:00 am, one medication cup was observed on Resident #25's bedside table located on the right side of Resident #25's bed. There were several pills in the medication cup. Resident #25 was sitting up in his bed.

An observation and interview were conducted on

self-administer medications.

On 10/28/24, resident #25 took medications as prescribed under the supervision of the Director of Nursing.

On 10/28/24, resident #62 took medications as prescribed under the supervision of the Director of Nursing.

On 10/28/24, the Director of Nursing educated resident #25 on the risks of not taking medications as prescribed by the physician to include risks of saving medications and taking at times not recommended by the physician. Resident #25 verbalized understanding of risks.

On 10/28/24, the Director of Nursing educated resident #62 on the risks of not taking medications as prescribed by the physician to include risks of saving medications and taking at times not recommended by the physician. Resident #62 verbalized understanding of risks.

On 11/8/24, the Director of Nursing completed an assessment for Medication Self Administration for resident #25. The resident was determined not safe to self-administer medications.

On 11/8/24, the Director of Nursing completed an assessment for Medication Self Administration for resident #62. The resident was determined not safe to self-administer medications.

On 10/29/24, the nurse supervisor

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F 554	Continued From page 2 10/28/24 at 9:15 am with Nurse #3. She was observed at the medication cart in the hallway outside Resident #25's room. Nurse #3 walked into Resident #25's room and reached for the medication cup with his medications on the bedside table and asked Resident #25 if he was ready to take his medications. Resident #25 started yelling at Nurse #3 and asked why she was in his room. Resident #25 told her to leave his medications alone. Nurse #3 then walked out of Resident #25's room into the hallway without the cup of medications and Resident #25 still had not taken his medications. Nurse #3 stated she should not have left the medication cup with his medications on the bedside table. Nurse #3 further stated she should have stayed in Resident #25's room and watched him swallow the medications. An interview was conducted with Resident #25 on 10/28/24 at 9:21 am, during which he stated he did not need anyone to watch him take his medications. Resident #25 further stated the nurses left his medication cup with medications on his bedside table for him to take but did not state how often the nurses left his medication on his bedside table. A follow-up interview was conducted on 10/28/24 at 2:28 pm with Nurse #3 who indicated she had not usually left the medication cups with medications on the bedside table. Nurse #3 further indicated that Resident #25 got upset when someone watched him take his medications as evidenced earlier that morning. During an interview with the Director of Nursing (DON) on 10/28/24at 3:30 pm, she explained that Resident #25 had not been assessed to perform	F 554	completed an audit of all resident rooms. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. There were no additional concerns identified. On 10/29/24, the Director of Nursing, Staff Facilitator, Nurse Supervisor and Treatment Nurse initiated Med Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The Director of Nursing and Staff Facilitator will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by 11/12/24. After 11/12/24, any nurse or medication aid who has not completed the audit will complete upon next scheduled work shift. On 10/29/24, the Director of Nursing and Staff Facilitator initiated an in-service with all nurses to include nurse #3 and medication aides regarding Rights of Medication Administration with emphasis on administering medication per physician order to include right medication at the right time and not leaving medication at bedside unless the resident had been	

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F 554	Continued From page 3 self-administration of his medication. She further stated Resident #25's medications should not have been left on the bedside table and Nurse #3 should have watched Resident #25 take his medications before she left his room. 2. Resident #62 was admitted to the facility on 11/2/22. Resident #62's quarterly MDS assessment dated 10/14/24 revealed Resident #62 was cognitively intact. Physician orders included the following medication orders for Resident #62 that were active on 10/28/24: -Amlodipine Besylate 10 mg tablet give one tablet one time a day for hypertension -Aspirin 81 mg tablet give one tablet one time a day for anticoagulant -Oxybutynin Chloride 10 mg tablet give one tablet one time a day for bladder spasms -Empagliflozin 25 mg tablet give one tablet one time a day for diabetes mellitus -Meloxicam 15 mg tablet give one tablet in the morning for right knee pain with food -Multiple Vitamin-Mineral tablet give one tablet one time a day for supplement -Omega-3 500 mg oral capsule give one capsule in the morning for low lipoprotein level give with meal -Metformin HCl 500 mg tablet give one tablet two times a day for diabetes mellitus There was no documentation in the EMR that Resident #62 had been assessed to self-administer her medications. There was no physician's order for self-administration, and there was no care plan that addressed	F 554	assessed to safely self-administer medications and physician order obtained. In-service will be completed by 11/12/24. After 11/12/24, any nurses or medication aid who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and or medication aides will be in-serviced during orientation regarding Rights of Medication Administration. The Nurse Supervisor, Staff Facilitator, Director of Nursing, Quality Improvement Nurse will complete 5 Med Pass Audits with nurses to include nurse #3 and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. Audits will include all shifts and weekends. The Nurse Supervisor, Director of Nursing, Staff Facilitator, Quality Improvement Nurse will address all concerns identified during the audit to include but not limited to re-education of staff. The Administrator will review the Med Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Nurse Supervisor, Staff Facilitator, Quality Improvement Nurse will audit 10 resident rooms to include resident #25 and resident #62 twice weekly x 4 weeks	

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F 554	Continued From page 4 self-administration of medication. During an observation on 10/28/24 at 8:30 am, a medication cup was observed on Resident #62's bedside table located on the left side Resident #62's bed. There were several medications in the medication cup. Resident #62 was lying in her bed. During an interview with Nurse #3 on 10/28/24 at 9:15 am, she stated she was the assigned nurse for Resident #62. Nurse #3 further stated she should not have left Resident #62's medication cup with her medications on the bedside table. Nurse #3 indicated she should have stayed in Resident #62's room and watched her swallow the medications. In an interview with Resident #62 on 10/28/24 at 2:16 pm, she stated she liked to take her medications with milk. Resident #62 further stated the nurses left her medication cup with medications on her bedside table to take with breakfast. Resident #62 indicated this happened more than once during the week. In a follow-up interview with Nurse #3 on 10/28/24 at 2:26 pm, she stated she should not have left the resident's medication cup with medications on the bedside table. Nurse #3 indicated she had been called to another resident's room for a situation and without thinking she left Resident #62's medication cup with her medications on the bedside table. Nurse #3 stated she should have taken the medication cup with the medications back to the medication cart and returned with Resident #62's medications after evaluating the situation with another resident.	F 554	then monthly x 1 month. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The Nurse Supervisor, Staff Facilitator, Quality Improvement Nurse will address all concerns identified during the audit to include ensuring medications are administered per physician order and/or re-training of staff. The Director of Nursing will review the room audits twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance Nurse will present the findings of the Med Pass Audits and Room Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 554	Continued From page 5 During an interview with the DON on 10/28/24 at 3:30 pm, she explained that Resident #62 had not been assessed to perform self-administration of her medication. She further stated Resident #62's medications should not have been left on the bedside table. Nurse #3 should have watched Resident #62 take her medications before she left her room.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		11/13/24

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F 582	Continued From page 6 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a complete Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services by omitting the options checked section indicating a resident's decision to continue part A Medicare services and by omitting the resident's signature on the form for 2 of 3 residents (Resident#170 and Resident #7) reviewed for beneficiary protection review. The findings included:	F 582	F582 Liability Notice Resident #170 was discharged home per preference on 9/6/24 and no longer resides in the facility. On 11/7/24 the Social Worker reviewed with resident #7, the process of notification of medical non-coverage letters to include checking the desired box of Medicare billing options and signing form when completed. An updated liability notice was completed and provided to resident #7 by the social worker with the	

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F 582	Continued From page 7 1. Resident 170 was admitted to the facility 8/21/24 and admitted to Medicare Part A services. Resident #170's Medicare Part A skilled services ended on 9/6/24 and he remained in the facility. The SNF ABN review revealed Resident 170's name, the date services were to end, the estimated cost of the services and Resident #170's signature. There were no options checked for the decision made about continuing Medicare Part A services. An interview was conducted with the facility Social Worker on 10/29/24 at 9:46 AM who stated Resident #170 did not choose an option for the decision made regarding continuing Medicare Part A skilled services. She stated that she did not document his refusal to choose an option. Attempts to contact Resident #170 were unsuccessful. An interview was conducted with the facility Administrator on 10/30/24 at 10:56 AM who stated the SNF ABN should have been completed with Resident #170's decision regarding continued Medicare Part A skilled services. She stated if Resident #170 refused to choose an option it should have been documented on the form. 2. Resident #7 was admitted to the facility on 11/16/20. She was admitted to Medicare Part A services on 9/6/24. Resident #7's Part A services ended on 10/14/24 and she remained in the facility.	F 582	appropriate box checked and signature obtained. Validation was completed of this by the Administrator on 11/7/24. On 10/29/24, the Admissions Director completed an audit of all Medicare A discharges for the past 30 days. This audit was to ensure all Notifications of Medical Non-Coverage (NOMNC) were completed with the appropriate box checked for the desired Medicare billing options and signed by the resident/resident representative when completed. There were no additional concerns identified. On 10/29/24, the Administrator completed an in-service with the Accounts Receivable and Social Worker regarding Notifications of Medical Non-Coverage (NOMNC) with emphasis on (1) providing appropriate notification related to non-coverage of Medicare A residents with estimated cost of services, (2) ensuring the resident/resident representative checked the appropriate box for the desired Medicare billing options and signed the NOMNC when form completed and (3) providing a copy to the resident/resident representative. All newly hired Accounts Receivable and/or Social Workers will be in-serviced by the Staff Facilitator during orientation regarding Notifications of Medical Non-Coverage (NOMNC). 10% audit of all Medicare A discharges will be reviewed by the Admission Director and/or Director of Nursing weekly x 4	

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F 582	Continued From page 8 The SNF ABN review revealed Resident 170's name, the date services were to end, and the estimated cost of the services. There were no options checked for the decision made about continuing Medicare Part A services and there was no signature on the form. An interview was conducted with the facility Social Worker on 10/29/24 at 9:46 AM who stated it was an oversight Resident #7 did not choose an option or sign the SNF ABN. She stated it was normal procedure for the form to be signed at the same time as the Notice of Medicare Non-Coverage (Form CMS 10123). An interview was completed with Resident #7 on 10/30/24 at 9:00 AM who stated she did not recall being presented with the ABN form. An interview was conducted with the facility Administrator on 10/30/24 at 10:56 AM who stated the SNF ABN should have been completed with Resident #7's decision regarding continued Medicare Part A skilled services and signed.	F 582	weeks then monthly x 1 month utilizing the NOMNC Audit Tool to ensure the appropriate notification of medical non-coverage was provided to the resident/resident representative to include cost of services, to ensure the appropriate box checked for desired Medicare billing option and the resident/resident representative signed the form when completed. The Admission Director and/or Director of Nursing will address all areas of concern to include reviewing with the resident/resident representative the process of completing notification of non-coverage, providing an updated copy to the resident/resident representative when indicated. The Staff Facilitator will re-educate staff for any concerns identified. The Administrator will review and initial the NOMNC Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		11/13/24

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F 689	Continued From page 9 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to secure smoking materials (cigarettes/lighters) for 2 of 4 residents sampled for smoking (Resident #23, Resident #106). Findings included: Review of the facility's revised smoking policy dated 3/27/2019 revealed all resident smoking materials are kept in a secure area and are accessible by facility staff only. 1. Resident #23 was admitted to the facility on 5/29/2019. The annual Minimum Data Set (MDS) dated 1/17/2024, revealed Resident #23 was cognitively intact. Review of the smoking assessment dated 10/1/2024 revealed Resident #23 was a safe/ independent smoker. Resident #23's revised care plan dated 10/16/2024 indicated he was an independent and safe smoker. On 10/28/2024 at 8:45 am Resident #23 was observed to have a pack of cigarettes and 2	F 689	F689 Free of Accident Hazards/Supervision/Devices On 10/28/24, medication aide #1 immediately removed all smoke paraphernalia to include a pack of cigarettes and two lighters from resident #23 and secured per facility protocol. On 10/28/24, the Nurse Supervisor educated the resident on the Smoking Policy to include storage of smoke paraphernalia and designated smoke areas. On 10/29/24, the treatment nurse updated the smoking assessment for resident #23. Resident #23□s care plan was updated for smoke supervision due to non-compliance with returning smoke paraphernalia per facility protocol. The resident was re-educated by the Administrator regarding smoke policy, consequences to violating smoke policy, and smoking supervision to include times for smoking. The resident verbalized understanding. On 10/29/24, the Director of Nursing removed all smoke paraphernalia to include a lighter from resident #106 and secured per facility protocol. On 10/29/24,	

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F 689	Continued From page 10 lighters on his bedside table in his room. An oxygen concentrator was also observed in Resident #23's room on the left side of the bed and was currently turned off. An interview was conducted on 10/28/2024 at 8:47 am with Medication Aide #1. She stated when a resident comes back from smoking, they are supposed to bring smoking materials to the staff so they can lock them on the medication cart. The Medication Aide #1 was observed to immediately remove Resident #23's smoking materials and locked them in the medication cart. An interview was conducted with Resident #23 on 10/28/24 at 8:52 am. Resident #23 stated he usually keeps his lighters at his bedside. An interview with Nurse Aide (NA) #1 was conducted on 10/29/2024 at 4:49 am. She stated she has never seen Resident #23 smoke in his room or have cigarettes/lighters at his bedside. In an interview with Nurse #1 conducted on 10/29/2024 at 6:03 am, she stated Resident #23 has never smoked in his room. An observation of Resident #23 was conducted on 10/29/24 at 12:01 pm in the designated smoking area; no concerns were noted. 2. Resident #106 was admitted to the facility on 12/4/2023. The annual Minimum Data Set (MDS) dated 12/11/2023, revealed Resident #106 was cognitively intact. Review of the smoking assessment dated	F 689	the resident was educated by the Administrator regarding smoke policy, consequences to violating smoke policy, and smoking supervision to include times for smoking. The resident verbalized understanding. On 11/8/24, the treatment nurse updated the smoking assessment for resident #106. Resident #106□s care plan was updated for smoke supervision due to non-compliance with returning smoke paraphernalia per facility protocol. The resident was re-educated by the Director of nursing regarding smoke policy, consequences to violating smoke policy, and smoking supervision to include times for smoking. The resident verbalized understanding. On 10/29/24, the Admission Director completed an audit of all resident rooms for smoking paraphernalia. This audit is to identify any resident in possession of smoking paraphernalia that was not secured per facility protocol. There were no additional concerns identified during the audit. On 10/29/24, the Administrator and Director of Nursing completed questionnaires with all alert and oriented residents who smoke regarding (1) Have you been educated on the facility smoking policy to include consequences to violating smoke policy? (2) Do you understand that all smoke material must be secured at the nurse□s station and not stored in resident rooms for safety of all	

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F 689	Continued From page 11 4/2/2024revealed Resident #106 was a safe/ independent smoker. Resident #106's revised care plan dated 4/2/2024 indicated he was an independent and safe smoker. On 10/29/2024 at 11:45 am Resident #106 was observed in a Resident Council meeting with a cigarette lighter attached to a flap of a crossbody type bag. An observation of Resident #106 was conducted on 10/29/24 at 12:01 pm in the designated smoking area; no concerns were noted. An interview was conducted with Resident #106 on 10/29/2024 at 12:01 pm. He stated he always keeps his lighter with him, but the staff keep his cigarettes. An interview with Nurse #2 was conducted on 10/29/2024 at 12:14 pm. She stated she was not aware of a lighter attached to Resident #106's bag. She further stated residents who smoke were expected to return all cigarette packs and lighters after smoking. An interview was conducted with NA #2 on 10/29/2024 at 12:17 pm. She stated she never saw Resident #106 with a lighter. She added residents who smoke asked for their cigarettes and lighters from staff before they went to the smoking area. During an interview with NA #3 conducted on 10/29/2024 at 12:22 pm, NA#3 stated she was not aware Resident #106 had a lighter. She further stated if she found cigarettes or lighters in	F 689	residents? (3) Do you understand that smoking with Oxygen is dangerous and could cause an explosion? (4) Do you know where the designated smoking area is located? (5) Do you understand that smoking is not allowed outside of these areas? This questionnaire was to ensure residents who desire to smoke was educated on the smoke policy to include storage of smoke paraphernalia and consequences of violating smoke policy. The Administrator and/or Director of Nursing will address all concerns identified during the questionnaires to include education of the resident and removal of smoke paraphernalia when indicated. There were no additional concerns identified. On 10/29/24, the Staff Facilitator initiated questionnaires with all staff regarding Smoking with emphasis on (1) Do you know of any resident who smokes or has verbalized a desire to smoke, that has not already been identified as a smoker? (2) Do you know of any resident who has smoking paraphernalia to include lighters/matches/vapes or cigarettes in their room and (3) Do you understand that all smoking paraphernalia must be secured at the nurse□s station and that smoke paraphernalia may not be stored in resident room? The Staff Facilitator and/or Director of Nursing will address all concerns identified during the questionnaire to include education of staff for removal of smoke paraphernalia when indicated, and reporting incidents to the Administrator/DON. The questionnaires	

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F 689	Continued From page 12 a resident's room, she would go directly to the nurse. An interview was conducted with the Administrator on 10/29/2024 at 10:24 am. She stated some residents can be very resourceful. Regarding Resident #23, she further stated Resident #23 does not allow staff to search his room. An interview was conducted with the Director of Nursing on 10/29/2024 at 1:20 pm. She stated per the facility's smoking policy, residents are not supposed to keep lighters with them. Staff have explained the smoking policy many times to residents.	F 689	will be completed by 11/12/24. After 11/12/24, any staff who have not worked or completed the questionnaires will complete it upon the next scheduled work shift. On 10/29/24, the Director of Nursing completed a review of all nursing progress notes for the past 7 days. This audit was to identity any incidents related to smoking paraphernalia not being returned to a secure location when the resident was in the facility. There were no additional concerns identified. On 10/29/24, the Director of Nursing and Administrator reviewed all incidents for the past 30 days. This audit was to identify any incidents related to smoking in non-designated areas or failure to secure smoke paraphernalia per facility protocol. There were no additional concerns identified. On 10/29/24, the Minimum Data Set Nurse (MDS) initiated an audit of all smoke assessments/care plans for residents who smoke or desire to smoke. This audit is to ensure the resident was assessed for smoke safety to include compliance with returning smoke paraphernalia to secured location and the care plan accurately reflects resident smoke safety as supervised or independent safe smoker. The MDS nurse and/or Director of Nursing will address all concerns identified during the audit to include assessment of the resident, updating care plan for smoke	

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F 689	Continued From page 13	F 689	safety and/or education of staff. The audit will be completed by 11/12/24. On 10/29/24, the Administrator, Activity Director and Director of Nursing held an impromptu meeting with all alert and oriented residents who smoke or desire to smoke regarding the Smoke Policy with emphasis on designated smoking, where to store smoking paraphernalia, hazards to smoking with oxygen and the consequences for violations of the smoke policy. Any alert and oriented resident who smokes or desires to smoke that did not attend the meeting were educated 1:1 by the Administrator. Education was completed on 10/29/24. On 10/29/24, the Staff Facilitator initiated an in-service for all facility staff regarding the Smoking Policy and Monitoring Smoking Paraphernalia to include immediately reporting to the supervisor or nurse any resident with smoke paraphernalia to include vapes, removing/securing smoke paraphernalia when indicated, reporting any resident who verbalizes a desire to smoke or is found to be vaping/smoking at the facility. In-services will be completed by 11/12/24. After 11/12/24, any staff who has not worked or completed the in-service will complete prior to the next scheduled work shift. All newly hired staff will be in-service during orientation by the SDC regarding the Smoking Policy and Monitoring Smoking Paraphernalia. On 10/29/24, Administrated placed bright	

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F 689	Continued From page 14	F 689	colored sign at the door to access the smoking area that reads residents please turn in all smoking materials to the nurse. The MDS nurse, Medical Records Director, Activities Director, and/or Staff Facilitator will audit 10% of resident rooms to include resident #23 and resident #106 utilizing the Smoking Paraphernalia Audit Tool weekly x 4 weeks, then monthly x 1 month. This audit is to identify any resident with smoke paraphernalia to include but not limited to lighters or cigarettes that is not secured per facility protocol. All areas of concern will be immediately addressed by the MDS nurse, Medical Records Director, Activities Director, and/or Staff Facilitator to include securing smoke paraphernalia, re-education, and assessment of the resident for smoke safety, initiating interventions to include but not limited increasing supervision, updating care plan for smoke safety/supervision of residents who are non-compliant with the Smoking Policy. The Director of Nursing and/or Administrator will review the Smoking Paraphernalia Audit Tool weekly x 4 weeks, then monthly x1 month to assure all areas of concern were addressed. The DON will present the findings of the Smoking Paraphernalia Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 1 months for review and to determine trends and/or issues that may need further interventions put into place or the need for further frequency of monitoring.	

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 690	F690 Bowel/Bladder Incontinence,	11/13/24

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F 690	Continued From page 16 facility record reviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 2 of 4 residents (Resident #87 and Resident #91) reviewed with urinary catheters. The findings included: 1. Resident #87 was admitted to the facility on 2/23/22 with diagnoses which included chronic kidney disease, benign prostatic hyperplasia, and urinary retention. Resident #87's care plan dated 9/6/24 revealed focus areas for urinary retention and at risk for infection. Interventions were to monitor for signs/symptoms of urinary retention and urinary tract infections (UTI's). An annual Minimum Data Set (MDS) assessment dated 9/12/24 revealed Resident #87 had severely impaired cognition. The assessment indicated Resident #87 was dependent upon staff for all of his activities of daily living (ADL). Resident #87 was coded for an indwelling catheter. An initial observation was conducted on 10/27/24 at 10:45 am of Resident #87 as he was lying in his bed. A urinary catheter bag was observed to be hanging off the bedframe on the resident's right side of the bed (with a solid, blue-colored side of the bag facing the doorway). The entire bottom of the urinary catheter bag was resting on the floor. The bag did not have a detachable cover. An additional observation was conducted on 10/28/24 at 2:34 pm Resident #87's urinary	F 690	Catheter, UTI On 10/30/24 resident #87 Catheter bag was repositioned by Treatment Nurse so that catheter bag was not positioned or touching the floor. On 10/30/24 resident #91 Catheter bag was repositioned by Treatment Nurse so that catheter bag was not positioned or touching the floor. On 10/30/24, the Treatment nurse completed an audit of all residents to include resident # 87 and resident #91 with catheter bags to ensure no catheter bag was positioned on or touching the floor. All areas of concern were immediately corrected during the audit by the Treatment Nurse to include repositioning the catheter bag, so it was not positioned on or touching the floor and the education of staff. On 10-29-24 the Staff Facilitator initiated an in-service with all nurses and nursing assistants (NA) regarding Positioning of Catheter Bags with emphasis on not positioning catheter bags on or touching the floor. If a resident□s bed must be in the lowest position possible then the catheter bag should be placed inside a black catheter sleeve to decrease the risk of infection. Attach the catheter bag to the foot of the bed and elevate the foot of the bed to a height so that the catheter bag is not positioned on or touching the floor. The in-service will be completed by 11-12-24 After 11-12-24 any nurse or nursing	

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F 690	Continued From page 17 catheter bag was observed to be hanging off the bedframe on the resident's right side of the bed. The entire bottom of the urinary catheter bag was resting on the floor. The urinary catheter bag did not have a detachable cover. On 10/28/24 at 2:45 pm, Resident #87 was observed to be in his bed with his urinary catheter bag hanging from the right side of the bed and again the entire bottom of the urinary catheter bag was touching the floor. In an interview with Nurse #3 on 10/28/24 at 2:45 pm, she stated was the hall nurse assigned to care for Resident #87. Nurse #3 was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, "It shouldn't touch the floor." The nurse stated she thought the urinary catheter bag ended up touching the floor due to the low position of Resident #87's bed. During a subsequent observation on 10/30/24 at 8:22 am, Resident #87 was observed in his bed with his urinary catheter bag hanging from the right side of the bed and again touching the floor. During an interview with the Director of Nursing (DON) on 10/29/24 at 3:51 pm, she expected the nursing staff to attach a urinary catheter bag to a resident's bed frame or geri chair and position the bag so it would not touch the floor to reduce the risk of infection. 2. Resident #91 was admitted to the facility on 1/24/23 with diagnoses which included chronic kidney disease, urinary tract infection (UTI), and urinary retention.	F 690	assistant who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses and NAs will be in-serviced regarding Positioning of Catheter Bags during orientation by the Staff Development Coordinator. The Treatment Nurse will audit of all residents with catheter bags to include resident # 87 and resident #91 utilizing the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure catheter bags are not positioned on or touching the floor. The Treatment Nurse will immediately address all identified areas of concern to include repositioning of catheter bag, so it is not positioned on or touching the floor and/or re-training of staff. The DON will review the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure all areas of concern have been addressed. The DON will forward the results of Catheter Bag Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 690	Continued From page 18	F 690		

A review of Resident #91's quarterly Minimum Data Assessment (MDS) dated 9/25/24 revealed Resident #91 was moderately cognitively impaired. Resident #91 was coded for indwelling catheter.

Resident #91's care plan dated 9/25/24 revealed focus areas for urinary retention and at risk for infection. Interventions were to monitor for signs/symptoms of urinary retention and urinary tract infections (UTI's).

An initial observation was conducted on 10/27/24 at 11:00 am of Resident #91 as she was lying in her bed. A urinary catheter bag was observed to be hanging off the bedframe on the resident's left side of the bed (with a solid, blue-colored side of the bag facing the doorway). The entire bottom of the urinary catheter bag was resting on the floor. The bag did not have a detachable cover.

During an interview on 10/28/24 at 2:45 pm, Nurse #3 was identified as the hall nurse assigned to care for Resident #91. Nurse #3 stated the resident's urinary catheter bag should not touch the floor. The nurse stated she thought the urinary catheter bag ended up touching the floor due to the low position of Resident #91's bed.

During an interview with the Director of Nursing (DON) on 10/29/24 at 3:51 pm, she expected the nursing staff to attach a urinary catheter bag to a resident's bed frame and position the bag so it would not touch the floor to reduce the risk of infection.