STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted on 05/07/19 through 05/09/19, was conducted 06/24/19 through 06/26/19. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level 4 Isolated, which constituted Substandard Quality of Care. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 170 certified bed facility was 158 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #101 through 112). The expanded survey sample consisted of eight current Resident reviews (Residents #113 through 120).	{F 000}		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		8/6/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/22/2019

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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F 577 Continued From page 1

years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, family interview and staff interview, the facility staff failed to post results of the most recent surveys for review by residents, families and/or their representatives, in a 170 bed facility with a census of 158.

The findings include:

On 6/24/19 at 2:50 p.m., an anonmous family member (FM) #1, asked about results of the last survey conducted in May 2019. The FM #1 stated she looked for the report but did not find it posted.

On 6/24/19 at 3:25 p.m., the facility's survey book located in the main lobby was inspected. The most recent survey posted in the book was dated 9/13/17. The facility's last standard survey completed on 10/25/18 and the most recent abbreviated survey completed on 5/9/19 were not posted.

On 6/24/19 at 3:50 p.m., the administrator was interviewed about not posting the most recent surveys. The administrator stated he was responsible for posting the survey results. The administrator stated he had been busy "working the poc [plan of correction]" and had not updated the survey book.

F 577

This Plan of correction does not constitute an
Admission or agreement by the provider of the truth of the facts
Alleged or conclusions set forth in the Statement of
Deficiencies. This plan of correction is prepared
Solely because it is required by state and federal law.

F 577

Survey results were updated and placed in the lobby on 6/24/2019

All resident have the potential to be affected. Survey results from re-visit 6/24/2019-6/26/2019 will be updated by the Executive Director in the survey book by 7/23/2019.
The facility management team will be educated by the RDCS on placement and accuracy of the survey results book by 8/6/2019.

The Executive Director will conduct quality monitoring of the location and accuracy of the survey results book weekly for 8

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F 577	Continued From page 2 This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.	F 577	weeks. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of Compliance: 8/6/2019	
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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);	{F 584}		8/6/19

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{F 584}	Continued From page 3 §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 observation, resident interview and staff interview, the facility failed to ensure a comfortable homelike environment in the smoking area courtyard for 43 of 158 residents in the facility. The patio furniture was observed in disrepair. The findings include: On 6/24/19 at 4:10 PM, the outside courtyard was observed. During the observation Resident #106 asked the surveyor to look at the wooden benches and described the benches as having broken wooden edges with chunks of wood missing and splintered. Both wooden benches was observed and each bench had chunks of wood broken off the seated part of the bench. The maintenance assistant (other staff, OS #3) was in the courtyard at the time of the observation and was interviewed regarding the benches that were in disrepair. OS #3 observed the benches and verbalized that the wood was possibly broken off due to wheel chair hitting	{F 584}	F 584 The courtyard benches were removed on 6/25/2019. All residents have the potential to be affected. A quality review will be completed by the Maintenance Director on all patio furniture to ensure a comfortable homelike environment by 7/26/2019. The Executive Director will educate Maintenance staff to ensure patio furniture is in good repair, and creates a comfortable homelike environment by 8/6/2019. Maintenance Director/designee to conduct quality monitoring of patio furniture to ensure furniture is in good repair and creates a comfortable homelike environment, 3 times weekly x 2 weeks, weekly x 4 weeks, then monthly x 3 months. Quality monitoring schedule modified based on findings. Maintenance staff will be assigned zone rounds to	

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{F 584} Continued From page 4

against the edge of the seat. OS #3 stated that the benches would be taken out of the courtyard.

On 6/25/19 at 9:15 AM, the maintenance director (OS #1) was interviewed concerning the benches. OS #1 stated that he didn't realize that the benches were in that bad of condition and would remove the benches.

On 6/25/19 at 3:20 the above information was presented to the administrator and director of nursing.

No other information was provided prior to exit conference on 6/26/19.

{F 584}

monitor common area furniture to include patio furniture daily. Quality monitor schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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 observation, clinical record review and staff interview, the facility staff failed to ensure an accurate MDS (minimum data set) for one of 20 residents in the survey sample, Resident #118. Resident #118 was not assessed as a current tobacco user on the most recent, full MDS assessment dated 12/27/18.

Findings include:

Resident #118 was admitted to the facility on 8/3/18, with the most current readmission on 12/20/18. Diagnoses for Resident #118 included, but were not limited to: high blood pressure, pneumonia, history of a stroke with aphasia,

F 641 — Completion date: 8/6/19

F 641

Resident #118's most recent full MDS assessment dated 12/27/2018 will be modified to accurately assess as a current tobacco user by 7/26/2019.

All residents who smoke have the potential to be affected. A quality review will be completed by MDSC on all smokers on their most recent, full MDS assessment to ensure these residents are accurately assessed as current tobacco users by 8/2/2019.

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F 641

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dementia, schizoaffective disorder, bipolar, and lack of coordination.

The most recent MDS was a quarterly assessment dated 6/21/19. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills.

The most recent full MDS assessment was a significant change assessment dated 12/27/18. This MDS assessed the resident with a cognitive score of "9" indicating moderate impairment in daily decision making skills. This MDS did not identify this resident as a current tobacco user.

The resident's admission MDS dated 8/10/18 was reviewed for comparison. This MDS assessed the resident as a current tobacco user in Section J. 1300.

On 6/25/19 at 3:15 PM, Resident #118 was observed in the smoking courtyard with OS (other staff) #4 sitting on a bench, smoking a cigarette.

The resident's clinical record was reviewed. A smoking assessment dated 11/01/18 documented, "Safe Smoking Evaluation...resident who wishes to smoke...perform evaluation at a significant change, or if there has been an incident of unsafe smoking observed or reported (or per facility policy)..."

The resident's kardex was reviewed (no date or times) and documented that the resident smokes, is an unsafe smoker, and is non-compliant with smoking times.

The resident's CCP (comprehensive care plan)

F 641

MDSC will be educated by corporate MDSC on accuracy of MDS assessments by 8/6/2019.

MDSC will conduct quality monitoring of MDS's for accuracy of assessment for tobacco use on 5 residents per week for 8 weeks. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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F 641	Continued From page 6	F 641		

was reviewed and documented, "...(Date initiated: 11/09/18)...is an unsafe smoker...instruct...about smoking risks and hazards and about smoking cessation...instruct...about the facility policy on smoking: locations, times, safety concerns...observe clothing and skin for signs of cigarette burns...safe smoking assessment upon admission and quarterly...(Date initiated: 6/24/19)...requires supervision while smoking..."

The resident had a smoking assessment completed in November 2018 and in June 2019.

On 6/25/19 at approximately 6:00 PM, the administrator, DON and CCS (corporate clinical specialist) were made aware of the above concerns regarding Resident #118 in a meeting with the survey team.

On 6/26/19 at 10:25 AM, the ADON (MDS coordinator) was interviewed regarding Resident #118's MDS. The ADON stated that she completed the MDS and that she obtains information from nurses, floor staff and sometimes residents. The ADON was asked in this case why the resident was not assessed as a current tobacco user, when the resident's chart, kardex and care plan all documented the resident as smoker/tobacco user. The ADON stated, "I really can't say." The ADON was asked if she spoke with staff or the resident regarding tobacco use. The ADON again stated, "I really can't say." The ADON was asked if this was an error. The ADON stated, "Yes, it was just an error."

No further information and/or documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM.

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{F 656}	Continued From page 7	{F 656}		
{F 656} SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	{F 656}		8/6/19

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

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{F 656} Continued From page 8

entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, family interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 20 residents in the survey sample. Resident #103 had no care plan developed regarding skin lesions on her face, shoulder and arms.

The findings include:

Resident #103 was admitted to the facility on 1/17/19 with diagnoses that included dementia with behaviors, anxiety, hypothyroidism, chronic pain syndrome and hyperlipidemia. The minimum data set (MDS) dated 5/3/19 assessed Resident #103 with short and long-term memory problems and severely impaired cognitive skills.

On 6/24/19 at 2:50 p.m., Resident #103 was observed in the day room. The resident had a dark brown-scabbed area on her right cheek and scattered red/pink lesions noted on her face and nose.

On 6/24/19 at 3:20 p.m., Resident #103 was observed in her room accompanied by a family member. The resident had a nickel sized scabbed area on the right cheek, scattered red/pink lesions and small scabbed areas across her face and nose. Some of the scabbed areas had a small amount of bleeding present. The resident had an oval shaped scabbed area on the

{F 656}

F 656

Resident # 103 comprehensive care plans revised to include skin lesions on her face, shoulder and arms by 7/26/2019.

All residents have the potential to be affected. A quality review will be completed by ADON to validate with skin impairment have appropriate care plans in place with corresponding interventions 8/2/2019.

Nursing staff to include nursing administration and MDSC's will be educated by SDC on development and implementation of resident center care plans to include skin impairment by 8/6/2019.

ADON will conduct quality monitoring of care plans for 5 residents noted to have areas documented on skin assessments for accuracy, weekly for 8 weeks. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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{F 656}	Continued From page 9	{F 656}		

back, right side of her head visible through her hair. This scab was approximately 1/2 inch long and 1/4 inch wide. Another scabbed area was visible on the back of the resident's right hand. The family member was interviewed at this time about the visible skin lesions. The family member stated the resident had chronic skin lesions with some of the areas present "for years." The family member stated the most recent area was on the back of her head and treatment was started last Friday (6/21/19) with improvement seen since treatment. The family member stated the facility had provided ongoing treatments to the areas since the resident's admission.

Resident #103's clinical record documented weekly skin assessments indicating ongoing scabbed skin lesions. The most recent assessment dated 6/20/19 documented skin lesions/scabbed areas on the resident's right cheek, left shoulder, back of head with scratched/picked areas noted on both upper arms. Previous skin assessments dated 5/16/19 through 6/17/19 documented lesions on the left shoulder area, right hand and right inner arm. There was a physician's order dated 5/26/19 for cleansing and Band-Aid application to the right hand daily and as needed. An additional physician's order dated 6/21/19 required Bactroban ointment to left shoulder lesion and left occipital scalp lesion twice per day in addition to Lotrimin ointment to the left shoulder twice per day.

A physician's assistant (PA) progress note dated 6/21/19 documented, "...Patient has several skin lesions which are chronic but recently has been a concern to family. They do not have any recent

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diagnosis for these lesions but I am told the one of the left shoulder has been there most of her life. She has a new scabby weepy lesion on the left posterior scalp...It is very similar to the lesion on the left shoulder..."

Resident #103's plan of care (revised 6/24/19) included no problems, goals and/or interventions regarding the skin lesions. The plan listed the resident was at risk of pressure ulcer development due to incontinence but made no mention of the skin lesions or scabbed areas.

On 6/25/19 at 9:00 a.m., the licensed practical nurse (LPN #5) caring for Resident #103 was interviewed. LPN #5 stated the resident had chronic skin lesions and scabs. LPN #5 stated the family reported the skin lesion on the resident's shoulder had been there most of her life. LPN #5 stated the scattered lesions would "come and go" and the family chose not to biopsy the areas because of the resident's severe dementia. When asked about a plan of care regarding the lesions, LPN #5 stated the lesions should be on the care plan. LPN #5 stated the unit manager and MDS nurses were responsible for care plans.

On 6/25/19 at 9:50 a.m., the unit manager (LPN #4) was interviewed about a care plan regarding Resident #103's skin lesions. LPN #4 stated the lesions were marked on the skin assessment sheets but she did not know why they were not on the care plan. LPN #4 stated the MDS nurse was responsible for developing the care plans.

On 6/25/19 at 10:00 a.m., LPN #2, responsible for MDS and care plans, was interviewed about Resident #103's skin lesions. LPN #2 reviewed

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{F 656}	Continued From page 11 the care plan and stated she did not see any entry regarding the skin lesions. LPN #2 stated she recently added the resident's use of "geri-sleeves" to the plan but did not see anything on the plan about the skin lesions. This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.	{F 656}		
{F 657} SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	{F 657}		8/6/19

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{F 657}	Continued From page 12 assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for nine of 20 residents in the survey sample, Resident #'s 102, 118, 116, 114, 119, 106, 115, 113, and 108. 1. The facility staff failed to review and revise the CCP for Resident #102 in the area of swallowing/choking. 2. The facility staff failed to review and revise the CCP for Resident #118 in the area of smoking supervision, non-compliance and smoking material storage. 3. The facility staff failed to review and revise the CCP for Resident #116 in the area of non-compliant smoking. 4. Resident #114's CCP was not revised with individualized problems, goals and interventions regarding non-compliant smoking activities. 5. Resident #119's CCP was not revised with individualized problems, goals and interventions regarding non-compliant smoking activities. 6. Resident #106's CCP was not specific or individualized for non compliance in smoking. 7. Resident #115's CCP was not specific or individualized for non compliance in smoking. 8. Facility staff failed to revise a care plan for non-compliant smoking for Resident #113.	{F 657}	F 657 Resident #102 comprehensive care plan reviewed and revised in the area of swallowing/choking from the choking incident documented on 5/8/2019. A speech evaluation was completed on 7/23/2019 and indicated additional speech therapy services were not needed. Resident # 118 comprehensive care plan reviewed and revised for the storage and security of smoking materials as well as in the area of smoking supervision to specify non-compliance. Resident #118□s smoking material has been secured at the nurse□s station and is disseminated only during supervised smoking sessions. Resident # 118 comprehensive care plan reviewed and revised in the area of smoking supervision to specify non-compliance. Resident #116 comprehensive care plan will be reviewed and revised in the area of smoking supervision to specify that the resident is now an unsafe smoker, supervision required for cueing and/or assistance extinguishing cigarette butt. Resident #116 smoking assessment will be updated and revised to indicate an unsafe smoker, supervision required for cueing and/or assistance extinguishing cigarette butt. Resident #114 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance with proper storage of smoking materials. Resident	

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9. The facility failed to review and revise the care plan for use of a wanderguard for Resident #108.

Findings include:

1. Resident #102 was admitted to the facility on 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, intestinal disorder and GERD.

The most current MDS (minimum data set) was a quarterly assessment dated 5/27/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skillsThe resident was assessed as supervision with set up only for eating/meal consumption. The resident's mode of transportation was a wheelchair.

On 6/25/19 at 7:50 AM, Resident #102 was observed in the dining room on the dementia unit. The resident was in her wheelchair at a table, with her breakfast in front of her, in individual bowls. LPN (licensed practical nurse) #2 was sitting beside the resident and prompting the resident to eat her breakfast.

A record review for Resident #102 was completed. Nursing notes documented the following:

5/8/19 12:15 PM "Resident sitting in DR [dining room] eating lunch and became choked. Unable to speak...alerted by CNA [certified nursing assistant]...helmick maneovor [sic] given...start coughing and spit out food...states, "I'm fine..."

{F 657}

#119 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance smoking outside of designated smoking areas and improper storage of smoking materials. Resident #106 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance with proper storage of smoking materials. Resident # 115 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance with proper storage of smoking materials and bumming of cigarettes from other residents. Resident # 113 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance with supervised smoking times and bumming of cigarettes from other residents. Resident #108 comprehensive care plan will be reviewed and revised to remove the intervention under elopement risk/wander of a wander guard. All actions listed above completed by 7/26/2019

All residents have the potential to be affected. Care plans are updated during weekly meetings and as needed for accuracy. A quality review will be completed by MDSC on all residents who smoke to ensure care plan accuracy by 8/2/2019. A review will be completed by MDSC on residents who are currently care planned for a wander guard, cross reference to residents currently assigned

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5/8/19 1:15 PM "Checked on resident, no distress noted..."

5/13/19 5:30 PM "...ate supper without difficulty...Speech Referral completed..."

No Speech Referral for this resident was found in the resident's clinical record.

Skilled nursing notes were then reviewed from 5/19/19 through 5/25/19 and documented the following:

5/20/19 "...feeds self with tray set-up..feeds self with cueing from staff..." No information was documented in the swallowing section.

5/21/19 "...Is able to feed self after tray set-up. Needs much encouragement to stay on task...feeds self with cueing and assistance from one staff member..." No information was documented in the swallowing section.

5/22/19 "...feeds self with cueing from staff..." No information was documented in the swallowing section.

5/23/19 "...Is able to feed self after tray set up, needs much encouragement to stay on task..."

5/24/19 "...Requires 1 assist with toileting, ADL's, transfers, and feeding..." No information was documented in the swallowing section.

5/25/19 "...feeds self with tray set-up...requires total dependence with all meals this shift..." No information was documented in the swallowing section.

{F 657}

a wanderguard and have orders for functionality and placement of wanderguard to ensure care plan accuracy and implementation by 8/2/2019. A quality review will be completed by ADON on all residents who have had a speech evaluation in the past 30 days to ensure event triggering speech evaluation is care planned, accurate and implemented and all changes to consistency, and assistance with meals is accurate by 8/2/2019.

Licensed nurses/MDS Coordinator educated by the SDC related to care plan timing and revision, care plan is to be reviewed and revised by the interdisciplinary team as indicated including both the comprehensive and quarterly review assessments, care plans are to be updated with new Physician orders and changes in assessments as indicated to include smoking status, safety/supervision devices, and changes to level of supervision and assistance by 8/6/2019.

ADON to conduct quality monitoring on the development of comprehensive care plans for 10 random residents weekly for 8 weeks to ensure accuracy, development and implementation. Quality monitoring scheduled modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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Nursing notes from 6/4/19 through 6/17/19 documented Resident #102 frequently refused breakfast and lunch.

The resident's kardex was reviewed and documented, "...independent needs help at times, supervision, set-up..."

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...[Date initiated: 11/19/18] ADL self-care deficit related to dementia...Eating: ...able to feed herself...[Date initiated: 11/19/18] potential for imbalanced nutrition and fluids related to functional decline, dysphagia, debility, dementia...is dependent upon staff for provision of foods and fluids and feeding at times...Monitor/document/report as needed any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing, Refusing to eat...[Date initiated: 11/19/18]..." The resident's CCP did not include any information regarding the resident getting choked or any information regarding a speech consult/evaluation.

On 6/25/19 at approximately 3:50 PM, the DON (Director of Nursing), ADON (Assistant Director of Nursing), administrator, corporate clinical specialist was informed of the above concerns in a meeting with the survey team.

The DON, ADON and administrator stated that they were aware of Resident #102 choking, but did not provide any information regarding why the resident's CCP was not reviewed and revised to reflect the above information regarding Resident #102 becoming choked.

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No further information and/or documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM.

2. Resident #118 was admitted to the facility on 8/3/18, with the most current readmission on 12/20/18. Diagnoses for Resident #118 included, but were not limited to: high blood pressure, pneumonia, history of a stroke with aphasia, dementia, schizoaffective disorder, bipolar, and lack of coordination.

The most recent MDS (minimum data set) was a quarterly assessment dated 6/21/19. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills.

The most recent full MDS assessment was a significant change assessment dated 12/27/19. This MDS assessed the resident with a cognitive score of "9" indicating moderate impairment in daily decision making skills. This MDS did not identify this resident as a current tobacco user.

On 6/25/19 at 3:15 PM, Resident #118 was observed in the smoking courtyard with a OS (other staff) #4 sitting on a bench. Resident #118 had a small pocketbook with two zippers. The resident unzipped one and got a cigarette out of a pack and zipped it back, then the resident unzipped the other zipper and pulled out a blue lighter and lit the cigarette and put the lighter back and zipped it up. The resident smoked the cigarette. OS #4 (the activity director) had been observed multiple times during the survey process in the courtyard area and was asked if this was her job. OS #4 stated that Resident #118 needed to be supervised while smoking.

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The resident's clinical record was reviewed. A smoking assessment dated 11/01/18 documented, "Safe Smoking Evaluation...resident who wishes to smoke...perform evaluation at a significant change, or if there has been an incident of unsafe smoking observed or reported (or per facility policy)..."

This smoking assessment documented that the resident was an unsafe smoker, needed constant supervision while smoking and that the resident had poor decision making skills and cannot communicate why oxygen must be shut off prior to lighting a cigarette.

A smoking assessment dated 06/02/19 documented the exact same information as the smoking assessment dated 11/01/19.

The resident's kardex was reviewed (no date or times) and documented that the resident smokes, is an unsafe smoker, and is non-compliant with smoking times.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...(Date initiated: 11/09/18)...is an unsafe smoker...instruct...about smoking risks and hazards and about smoking cessation...instruct...about the facility policy on smoking: locations, times, safety concerns...observed clothing and skin for signs of cigarette burns...safe smoking assessment upon admission and quarterly...(Date initiated: 6/24/19)...requires supervision while smoking..." The CCP did not document any information regarding non-compliance [as documented on the kardex], nor any interventions for non-compliance. The CCP did not document any

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information regarding the storage of smoking materials to ensure safety.

The facility smoking policy documented, "Policies and Procedures...10/01/2018...unsafe smoker, will be supervised during defined smoking times in a designated smoking area...residents who choose to smoke will be evaluated upon admission/readmission, quarterly, after a change in condition, after incident and as needed...smoking assessment will also determine...safe or unsafe smoker and will be designated as supervised or unsupervised smoker...Smoking materials will be retained by designated staff...residents assessed as unsafe smoker and designated as a supervised smoker will be supervised during designated smoking times, staff will be assigned during designated smoking times to supervise resident smoking..."

The DON was asked about Resident #118's CCP regarding supervision and that the intervention (for safety) was just added on 6/24/19, although the resident had been identified to require supervision with smoking on the smoking assessment dated in November of 2018. The DON stated that, LPN #8 had asked LPN #2 about smokers on Monday (6/24/19) when the surveyors were observing smokers and stated that LPN #2 told LPN #8 to go and care plan all unsafe smokers to wear a smoking apron. The DON stated that LPN #8 then asked the DON and the DON told LPN #8 to only care plan the residents who have been assessed for and need an apron to have an apron and further stated that all unsafe smokers don't need aprons. The DON stated that is where that intervention update came from. The DON was asked why supervision was not part of the resident's care

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plan before now and why was the resident's care plan not specific to identify non-compliance with smoking and failed to provide interventions. The DON stated, "I can't answer that."

On 6/25/19 at 5:10 PM, an interview with Resident #118 was conducted. The resident was sitting in a chair and had a small red bag on her lap. Another resident was present during the interview and was identified as Resident #121, with a cognitive score of 15. Resident #118 was asked if staff normally go out with her when she smokes. The resident stated, "No, don't." Resident #121 stated, "She goes out by herself." Resident #118 was asked if she kept her cigarettes in room with her. The resident look bewildered and then shook her head "no", the resident was then asked about the purse she was carrying earlier in the courtyard with the cigarettes and lighter. The resident did not respond. The resident was asked if the her smoking materials are kept at the nurse's station. The resident nodded yes.

On 6/25/19 at approximately 6:00 PM, the administrator, DON and CCS (corporate clinical specialist) were made aware of the above concerns regarding Resident #118 in a meeting with the survey team.

No further information and/or documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM to evidence that the resident's CCP was reviewed and revised for supervision while smoking, non-compliance with smoking times, or appropriate/safe storage of smoking materials.

3. Resident #116 was admitted to the facility on 8/7/13. Diagnoses for this resident included, but

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were not limited to: high blood pressure, history of a stroke with hemiparesis, seizure disorder, anxiety, depression, and a history of falls.

The most current MDS (minimum data set) for Resident #116 was a quarterly assessment dated 6/20/19. This MDS assessed the resident as having a cognitive score of "1", indicating the resident had severe impairment in daily decision making skills.

The resident's annual MDS assessment dated 12/26/18 assessed the resident as a current tobacco user.

The resident was observed on 6/25/19 at 9:30 AM smoking in the courtyard. Two staff members were in the courtyard. Resident #116's cigarette was burned down to the filter, when CNA (certified nursing assistant) #2 looked at the resident and stated, "I'll take that." The CNA took it out of the resident's hand and extinguished it.

Resident #116's smoking assessment dated 6/21/19 documented that the resident's decision making skills are not reasonable, nor consistent and the resident's memory and ability to recall are not adequate. The summary of the smoking assessment documented, "Resident can light, manipulate, and extinguish cigarette safely...safe smoker...supervision needed while smoking: None..."

The resident's kardex documented, "...Smoking, safe smoker, non-compliant with smoking times..."

The resident's CCP (comprehensive care plan) documented, "...is a smoker...assess for safe

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{F 657}	Continued From page 21 smoking...instruct...about smoking risks and hazards...facility policy on smoking, locations, times, safety concerns...observe clothing and skin for signs of cigarette burns...behavior problem refuses foot rest...refuses incontinent care...verbally inappropriate towards staff...noncompliant with smoking policy..." On 6/25/19 at 3:45 PM, the DON, administrator, ADON and corporate clinical specialist were made aware in a meeting with the survey team of concerns regarding this resident. On 6//26/19 at 10:30 AM, the ADON was interviewed regarding this resident's CCP. The ADON stated, "As far as I know he [Resident #116] is non-compliant with smoke times." The ADON was asked if the CCP should be more specific and individualized to specify what the non-compliance is, to include interventions to address the non-compliance. The ADON stated, "Yes, it should be more specific and the interventions should be listed." No further information and/or documentation was presented prior to the exit conference on 6/25/19 at 5:15 PM. 4. Resident #114 was admitted to the facility on 11/26/18 with diagnoses that included cerebrovascular accident (stroke), seizures, coronary artery disease, high blood pressure and depressive disorder. The minimum data set (MDS) dated 6/18/19 assessed Resident #114 with moderately impaired cognitive skills. On 6/25/19 at 9:10 a.m., Resident #114 was observed smoking independently in the courtyard area without direct supervision. The resident was in the alcove beside the entrance door to the	{F 657}		

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courtyard and out of view of a staff member standing at the fountain end of the courtyard.

Resident #114's plan of care (revised 2/26/19) documented the resident was a "non-compliant smoker" and non-compliant with safety measures. The plan did not identify the specific non-compliant activities demonstrated by the resident and included no individualized goals and/or interventions regarding non-compliant smoking.

On 6/25/19 at 2:05 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about Resident #114's plan of care. LPN #3 stated the resident's non-compliance was related to smoking at non-designated times and bringing in smoking supplies from out of the facility. LPN #3 stated they encouraged the resident to smoke at scheduled times and to store his supplies in a locked box. LPN #3 stated the MDS nurses were responsible for care plan updates.

On 6/25/19 at 2:30 p.m., LPN #2, responsible for care plans was interviewed about Resident #114's plan. LPN #2 stated Resident #114's smoking was a topic at care plan meetings but no specifics about non-compliance were discussed. LPN #2 stated specific non-compliance was not listed or identified in the plan of care.

This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.

5. Resident #119 was admitted to the facility on 1/16/17 with a re-admission on 6/14/19. Diagnoses for Resident #119 included paranoid personality, schizophrenia, neuropathy, peripheral

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vascular disease, psychosis and cerebrovascular disease. The minimum data set (MDS) dated 4/9/19 assessed Resident #119 as cognitively intact.

On 6/25/19 at 9:53 a.m., Resident #119 was observed independently smoking at the end of the sidewalk adjacent to the parking lot at the front of the building. There were signs posted on the building wall beside the walkway stating no smoking was allowed in this area. Resident #119 was interviewed at this time about smoking outside of the facility in a non-designated smoking area. Resident #119 stated he frequently came outside to the front walk area to smoke. Resident #119 stated he liked the outside area at the front of the building better than the designated courtyard area. Resident #119 stated staff members had told him before not to smoke in the outside sidewalk area.

The resident's plan of care (revised 4/10/19) listed the resident was "non-compliant with smoking policy." The plan did not identify the specific non-compliant activities demonstrated by the resident and included no individualized goals and/or interventions regarding non-compliant smoking.

On 6/26/19 at 8:10 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #119's plan of care regarding non-compliant smoking. LPN #1 stated the resident frequently smoked "out front" on the sidewalk area and not in the designated smoking area. LPN #2 stated Resident #119 was often resistive to care and was at times difficult to re-direct. When asked what interventions were implemented to ensure he was smoking in a

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designated area, LPN #1 stated they tried to direct Resident #119 to the designated smoking area in the courtyard but he was not cooperative with re-direction. LPN #1 did not know why the care plan did not identify the resident's specific non-compliant behaviors or interventions.

This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.
6. Resident #106 was admitted to the facility on 7/14/15. Diagnoses for Resident #74 included; Anxiety, depression, asthma, and bipolar. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/24/19. Resident #106 was assessed with a score of 15 indicating cognitively intact.

On 6/25/19 Resident #106's medical record was reviewed. The care plan initiated on 12/03/18 documented that Resident #106 was noncompliant with smoking policy. The care plan did not indicate what the noncompliance was, there was also no specific interventions regarding noncompliance for smoking.

Resident #106's smoking evaluation dated 3/1/19 indicated that Resident #106 was a safe smoker and was able to independently light manipulate and extinguish a cigarette safely.

On 6/25/19 at 1:30 PM, the assistant director of nursing (ADON, staff person that created Resident #106's care plan) was interviewed. The ADON was asked what the noncompliance in smoking was. The ADON stated that Resident #106 noncompliance is not adhering to the scheduled smoking times. When asked about

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the intervention for noncompliance in smoking, the ADON pointed to an intervention that read "If reasonable, discuss [Resident name] behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable." This intervention was dated 12/3/18.

The ADON was asked how would staff (taking care of Resident #106) know what the noncompliance is and what to do about the concern by reading the care plan and was also asked, if the intervention was in place since 12/3/18, was the intervention effective. The ADON verbalized understanding and agreed that the care plan should be individualized and more clear.

On 6/25/19 at 3:20 PM the above information was presented to the administrator and director of nursing.

No other information was presented prior to exit conference on 6/26/19.

7. Resident #115 was admitted to the facility on 10/4/13. Diagnoses for Resident #115 included; Epilepsy, schizoeffective disorder, and diabetes. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/10/19. Resident #115 was assessed with a score of 9 indicating moderate cognitive impairment.

On 6/25/19 Resident #115's medical record was reviewed. The care plan initiated on 10/15/18 documented that Resident #115 was noncompliant with smoking policy. The care plan did not indicate what the noncompliance was, there was also no specific interventions regarding

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noncompliance for smoking.

Resident #115's smoking evaluation dated 6/24/19 indicated that Resident #115 was a safe smoker.

On 6/25/19 at 1:30 PM, the assistant director of nursing (ADON, staff person that created Resident #115's care plan) was interviewed to discuss Resident #115's care plan. The ADON was asked what the noncompliance in smoking was. The ADON stated that Resident #115 noncompliance is not adhering to the scheduled smoking times. When asked about the intervention for noncompliance in smoking, the ADON pointed to an intervention that read "If reasonable, discuss [Resident name] behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable." This intervention was dated 10/15/18.

This surveyor pointed out to the ADON that Resident #115's care plan and Resident #106's care plan was identical and not specific. The ADON reviewed both Resident's care plan and verbalized understanding and agreed that the care plan should be individualized and more clear.

On 6/25/19 at 3:20 PM the above information was presented to the administrator and director of nursing.

No other information was presented prior to exit conference on 6/26/19.
8. Resident #113 was originally admitted to the facility on 08/23/2018 and readmitted on 09/09/2018 with diagnoses including, but not limited to: Congestive Heart Failure,

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Hypertension, Schizophrenia, Dysphagia, and Abnormal Gait.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/31/2019. Resident #113 was assessed as severely impaired in his cognitive status with a total cognitive score of three (3) out of 15.

Resident #113's comprehensive care plan (CCP) was reviewed on 06/25/2019 at 2:00 p.m. Listed in his CCP "Focus" area was "...non-compliant smoker...unsafe smoker. Date Initiated 09/26/2018." The Goal and Interventions were, "...will not suffer injury from unsafe smoking practices through the review date. Date Initiated: 09/26/2018. Instruct...about smoking risks and hazards and about smoking cessation aids that are available. Instruct...about the facility policy on smoking: locations, times, safety concerns...requires supervision while smoking. Observe clothing and skin for signs of cigarette burns."

The ADON (assistant director of nursing) was interviewed on 06/25/2019 at 2:20 p.m. regarding Resident #113's non-compliance. The ADON stated, "His non-compliance is the smoking times. He tries to bum cigarettes from other residents if he doesn't have any on his person." The ADON was asked who is smoking during these times. The ADON stated, "Other non-compliant residents. We try to redirect them, have them put their stuff in the locked box on the unit. We can't force them to hand over their stuff."

LPN #7 (licensed practical nurse) was

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interviewed on 06/25/2019 at 2:30 p.m. regarding Resident #113's smoking non-compliance. LPN #7 stated, "Right now he doesn't have anything. His brother hasn't been by to get him anything. He doesn't go by the smoking times. He panhandles for cigarettes and has to be redirected at times." LPN #6 and RN #1 (registered nurse) were present during the interview with LPN #7 and concurred with her statements.

On 06/25/2019 during a meeting with the survey team the Administrator and DON were informed of Resident
#113's non-specific care plan for smoking and his non-compliance. No further information was received by the survey team prior to the exit conference on 06/26/2019.
9. Resident #108 was admitted to the facility on 6/21/17 with the most recent readmission on 10/16/17. Diagnosis for Resident #108 included anxiety disorder, cardiac murmur, muscle weakness, polyosteoarthritis, depression, osteoporosis, dementia with behavioral disturbance, hypertension, and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) dated 6/20/19 assessed Resident #108 with severely impaired cognitive skills. Under section E 0900 Wandering, Resident #108 was coded as "behavior not exhibited."

Review of Resident #108's current care plan dated 10/31/18 with a goal target date of 7/15/19, indicated that Resident #108 was an "elopement risk/wanderer r/t (related to) impaired safety awareness." One of the interventions was "check placement of wanderguard every shift, and

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function every shift."

The clinical record was reviewed and did not include an order for a wander guard, nor was there any documentation of a wandergard on the March, April, May, or June 2019 TARs (treatment administration record).

On 6/25/19 from 8:55 a.m. to 9:20 a.m., Resident #108 was observed in the dining room, going to her room, propelling herself in the hall, and then back again in the dining room. A wanderguard was not observed on Resident #108 during this time.

On 6/25/19 at 9:26 a.m. CNA (certified nursing assistant) #10 was interviewed about the care plan interventions for Resident #108. CNA #10 stated that Resident #108 was not wearing a wanderguard, nor was she supposed to have a wanderguard. CNA #10 checked Resident #108 and verified she was not wearing a wanderguard.

At 9:50 a.m., LPN (licensed practical nurse) #4, who was also the unit manager, was asked about Resident #108's wanderguard and if a wanderguard needed a physician order. She stated that a physician order was needed and that Resident #108 had never had a wanderguard since being on the 3rd floor (dementia unit). She stated Resident #108 was admitted to the unit in October 2017. When asked how the MDS coordinator knew how to discontinue or update a care plan, LPN #4 stated that yellow copies of order changes go to the MDS coordinator so they update the care plan.

On 6/25/19 at 10:22 a.m., LPN #2, the MDS coordinator, was interviewed regarding the

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{F 657}	Continued From page 30 wanderguard for Resident #108. She stated that they "just took the wanderguard off her in the last couple of weeks." LPN #2 was asked for a physician discontinuation (d/c) order for the wander guard. On 6/25/19 at 11:31 a.m., the DON (director of nursing) stated that there was not a d/c order for the wanderguard, that Resident #108 never had a wanderguard, and that is was a care plan intervention error. She stated that Resident #108 would not wear the wanderguard and was placed on 15 minute checks instead. No further information was provided prior to the exit conference on 6/26/19.	{F 657}		
{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 observation, resident interview, staff interview, group interview, facility document review, and clinical record review, facility staff failed to ensure adequate supervision to prevent accidents for 7 of 20 residents in the survey sample. Resident #113 and Resident #118 were assessed and care planned as unsafe smokers. Resident	{F 689}	F 689 Resident #113s skin was assessed on 6/25/2019 with no negative findings. A cigarette holder was purchased for Resident #113. Resident #113s smoking assessment will be updated to reflect him as an unsafe smoker in addition to requiring supervision, and	8/6/19

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#113 was observed smoking in an unsafe manner without supervision. For Resident #118, the facility failed to limit the accessibility of a lighter and cigarettes. The facility failed to implement their policy for smoking at designated times and locations, and the policy did not define who was responsible for providing supervision. This resulted in Immediate Jeopardy (IJ) and SQC (substandard quality of care) which was identified in the area of Quality of Care on 6/25/19 at 7:00 p.m. The plan of removal for the immediacy was accepted on 6/25/19 at 8:00 p.m. The IJ was abated on 6/26/19 at 4:05 p.m. with the Scope and Severity lowered to Level II, Pattern.

The facility failed to implement safety protocols for smoking for 4 residents; #114, #119, and #116.

The facility failed to provide supervision to prevent accidents for Resident #102 and #108.

Findings included:

1. On 6/24/19 at 2:30 PM, a group interview was conducted with eleven cognitively intact residents. The group was asked about supervision while smoking. Resident #106 stated that there was no supervision, people go out at all times and smoke, and the residents were supposed to be putting their cigarettes in a box but they don't do that all the time. Resident #106 stated that the only reason there is a staff member out there today is because the surveyors are at the facility. Other residents in the group were nodding their heads in agreement.

2. Resident #113 was originally admitted to the facility on 08/23/2018 and readmitted on

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cueing and/or assistance extinguishing cigarette butt. Resident #113 comprehensive care plan will be updated to reflect unsafe smoking status, interventions of supervision, cueing and/or assistance extinguishing cigarette butt and smoking non-compliance with designated supervised smoking times, and bumming of cigarettes from other residents and will also be included on Resident # 113 Kardex. Resident #118 room and storage items were searched by ED and DON on 6/25/2019 without findings of smoking materials. Resident #118 comprehensive care plan updated to reflect conversation with ED and DON about proper storage of smoking materials. Resident #118 comprehensive care plan reviewed and revised in the area of smoking supervision to specify non-compliance as requiring supervision but does not comply with posted supervised smoking times, and non-compliance with smoking material storage and will also be included on Resident #118 Kardex. Resident #116 smoking assessment will be updated and revised to indicate an unsafe smoker, supervision required for cueing and/or assistance extinguishing cigarette butt. The care plan will be updated to reflect smoking status and interventions updated to reflect supervision required while smoking and will also be included on Resident # 116 Kardex. Education will be provided by DON/ADON/SDC to documented staff member (LPN #2) and other staff members responsible for assisting Resident # 102 with meals per

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09/09/2018 with diagnoses including, but not limited to: Congestive Heart Failure, Hypertension, Schizophrenia, Dysphagia, and Abnormal Gait.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/31/2019. Resident #113 was assessed as severely impaired in his cognitive status with a total cognitive score of three (3) out of 15.

On 6/24/19 at 4:10 p.m. a maintenance assistant (OS #3) was interviewed concerning supervision of residents that smoke in regards to needed supervision and safety apparatus. OS #3 stated that he was sent out to the smoking area to watch the residents but was not sure of each individual's needs and that the activity director had all that information.

On 6/24/19 at 4:25 p.m., Resident #113 was observed smoking in the facility's designated smoking area without staff supervision. Resident #113 was in his wheelchair at the end of the courtyard area near the automatic double doors along with five other smoking residents. Resident #113 held a burning cigarette between his right index and third fingers, smoking the cigarette down to the filter. As Resident #113 continued to smoke the cigarette down to the filter, another resident approached Resident #113 telling him to put out the cigarette. The other resident stated loudly, "You are smoking the filter [Resident #113]. You are going to burn your fingers." The other resident came from where she was sitting, and got closer to Resident #113, repeatedly telling him to put out the cigarette stating, "There is nothing left" and that he was going to burn his

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her comprehensive care plan. A speech evaluation was completed on 7/23/2019 and did not indicate additional speech therapy services were needed. This education will also include requirements of dining room supervision during meal times. Resident #114 smoking evaluation was completed in its entirety on 6/25/2019 and indicates the resident is a safe smoker. Resident #114 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance with proper storage of smoking materials. Documented staff member (LPN #3) will be educated on importance of completing assessments as indicated in a timely and complete manner. Resident #119 comprehensive care plan will be reviewed and revised to address non-compliant smoking activities to include non-compliance smoking outside of designated smoking areas and improper storage of smoking materials. Resident #119 has a BIMS of 15 and is educable. Resident #119 will be provided one on one education by the Executive Director regarding facilities smoking policy, to include proper storage of smoking materials and requirements for resident smoking to occur in the designated smoking area and potential recourse for continued unsafe non-compliance. Education will be provided by DON/ADON/SDC to staff caring for Resident # 108 regarding care plan items and interventions that address safety, supervision and preferences and will ensure these items are placed on the

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fingers. After repeated verbal warnings from the other resident, Resident #113 slowly propelled to the receptacle and extinguished the cigarette. Resident #113 had no smoking apron or assistive devices in use while smoking. There were no staff members present directly supervising or in the area of Resident #113 during this observation. The only staff person in the courtyard at this time was a maintenance employee (other staff - OS #7). OS #7 was at the opposite end of the courtyard working on another resident's wheelchair during the entire time Resident #113 smoked the cigarette.

Resident #113's "Safe Smoking Evaluation" was located during the clinical record review on 06/25/2109 at 2:00 p.m. Smoking evaluations had been completed on 09/06/18, 12/07/18, 03/05/19 and 05/31/19. All four evaluations documented that Resident #113 was an unsafe smoker. Specifically the "Summary of Evaluation" included: 09/06/18 - "Res. [resident] unable to hold/put on (sic) cigarette safely. Res. is MR [mentally retarded]." 12/07/18 - "Unable to hold or put out cigarette safely. Res. is MR." 03/05/19 - "Unable to hold or put out cigarette safely. Res. is MR." 05/31/19 - Unable to put out cigarette properly." All four assessments had been completed and signed by LPN #7 (licensed practical nurse).

LPN #7 was interviewed on 06/26/2019 at 11:20 a.m. on how Resident #113's Safe Smoking Evaluations had been completed. LPN #7 stated, "I asked him the questions and observed him while smoking."

Listed in Resident #113's comprehensive care plan (CCP) "Focus" area was "...non-compliant

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Kardex. All actions listed above will be completed by 7/26/2019.

All residents choosing to smoke have the potential to be affected. The DON and ED will conduct a quality review of all resident smokers to review individual smoking assessments to re-identify unsafe smokers, review unsafe smokers care plans to ensure smoking safety protocols are in place, documented and on the residents Kardex. The DON and ED will additionally, review safe smokers care plan for compliance status, and for resident smokers identified as non-compliant ensure specific non-compliance is documented, and ensure smoking safety protocols are in place documented and on the residents Kardex. A quality review will be completed by ADON on all residents who have had a speech evaluation in the past 30 days to ensure event triggering speech evaluation is care planned, accurate and implemented and all changes to consistency, and assistance with meals is accurate to provide supervision and prevent accidents. A quality review will be completed by ADON on residents with falls within the last 30 days to ensure fall interventions are documented; care planned, placed on the residents Kardex and verifies interventions are in place for the resident. These quality reviews will be completed by 8/2/2019.

Nursing staff to be educated by SDC on supervision of at risk residents, reading care plans and Kardex□s as it relates to

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smoker...unsafe smoker. Date Initiated 09/26/2018." The Goal and Interventions were, "...will not suffer injury from unsafe smoking practices through the review date. Date Initiated: 09/26/2018. Instruct...about smoking risks and hazards and about smoking cessation aids that are available. Instruct...about the facility policy on smoking: locations, times, safety concerns...requires supervision while smoking. Observe clothing and skin for signs of cigarette burns."

The ADON (assistant director of nursing) was interviewed on 06/25/2019 at 2:20 p.m. regarding Resident #113's non-compliance. The ADON stated, "His non-compliance is the smoking times. He tries to bum cigarettes from other residents if he doesn't have any on his person." The ADON was asked who is smoking during these times. The ADON stated, "Other non-compliant residents. We try to redirect them, have them put their stuff in the locked box on the unit. We can't force them to hand over their stuff."

LPN #7 was interviewed on 06/25/2019 at 2:30 p.m. regarding Resident #113's smoking non-compliance. LPN #7 stated, "Right now he doesn't have anything. His brother hasn't been by to get him anything. He doesn't go by the smoking times. He panhandles for cigarettes and has to be redirected at times." LPN #6 and RN #1 (registered nurse) were present during the interview with LPN #7 and concurred with her statements.

Included on Resident #113's "Nurse Tech Information Kardex" under "Special Considerations" was "Unsafe Smoker." The DON

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supervision of residents to prevent falls, supervision during meal times, smoking safety protocols, and required supervision during designated smoking times for unsafe smokers by 8/6/2019.

ED to conduct quality monitoring of 5 smokers per week for 8 weeks to monitor for appropriate supervision during designated smoking times, and compliance with safe smoking protocols. The DON to conduct quality monitoring of 5 residents with falls per week for 8 weeks to monitor for appropriate supervision and implementation of fall interventions. Manager on duty to conduct quality monitoring for supervision during meal times for 2 meals per day, 2 units per day, 5 times per week for 2 weeks, 3 times per week for 2 weeks, weekly for 4 weeks, then monthly for 2 months. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary

Allegation of compliance: 8/6/2019

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(director of nursing) stated, "This is the care plan the aides use to care for the residents."

Per the facility, defined smoking times were documented as follows: "Effective 5/9/17 the following units will be responsible for taking the residents that smoke out at the following times: 3N/S [north/south] - 10 AM, 3N/W [north/west] - 2 PM, 2/W [west] - 4 PM, 2 N/S [north/south] - 7 PM."

On 06/25/2019 during a meeting with the survey team the Administrator and DON were asked how staff from the specific units know who is assigned to watch smoking residents at the designated times. The DON stated, "The unit manager or the charge nurse assign specific employees for the designated smoking times, but that doesn't mean the staff can't switch off with another staff member."
3. Resident #118 was admitted to the facility on 8/3/18, with the most current readmission on 12/20/18. Diagnoses for Resident #118 included, but were not limited to: high blood pressure, pneumonia, history of a stroke with aphasia, dementia, schizoaffective disorder, bipolar, and lack of coordination.

The most recent MDS (minimum data set) was a quarterly assessment dated 6/21/19. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills. The resident was assessed as requiring supervision for bed mobility, transfers and ambulation and extensive assistance of one for dressing, toileting, hygiene and bathing.

The most recent full MDS assessment was a

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significant change assessment dated 12/27/19. This MDS assessed the resident with a cognitive score of "9" indicating moderate impairment in daily decision making skills. This MDS did not identify this resident as a current tobacco user.

On 6/25/19 at 3:15 PM, Resident #118 was observed in the smoking courtyard with a OS (other staff) #4 sitting on a bench. Resident #118 had a small pocketbook with two zippers. The resident unzipped one and got a cigarette out of a pack and zipped it back, then the resident unzipped the other zipper and pulled out a blue lighter and lit the cigarette and put the lighter back and zipped it up. The resident smoked the cigarette. OS #4 (the activity director) had been observed multiple times during the survey process in the courtyard area and was asked if this was her job. OS #4 stated that Resident #118 needed to be supervised while smoking.

Resident #118's clinical record was reviewed. A smoking assessment dated 11/01/18 documented, "Safe Smoking Evaluation...resident who wishes to smoke...perform evaluation at a significant change, or if there has been an incident of unsafe smoking observed or reported (or per facility policy)..." This smoking assessment documented that the resident was an unsafe smoker, needed constant supervision while smoking, had poor decision making skills and could not communicate why oxygen must be shut off prior to lighting a cigarette.

A smoking assessment dated 06/02/19 documented the exact same information as the smoking assessment dated 11/01/19.

The resident's kardex was reviewed (no date or

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times) and documented that the resident smokes, is an unsafe smoker, and is non-compliant with smoking times.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...(Date initiated: 11/09/18)...is an unsafe smoker...instruct...about smoking risks and hazards and about smoking cessation...instruct...about the facility policy on smoking: locations, times, safety concerns...observe clothing and skin for signs of cigarette burns...safe smoking assessment upon admission and quarterly...(Date initiated: 6/24/19)...requires supervision while smoking..." The CCP did not document any information regarding supervision prior to 6/24/19, did not document any information regarding non-compliance [as documented on the kardex], nor interventions for non-compliance and did not document any information regarding storage or handling smoking materials.

The facility smoking policy, "Smoking-Supervised and Unsupervised, Effective Date: 10/01/2018" included: "Policy: [Name of Facility] will provide a safe, dedicated smoking area for residents. Residents, who have been assessed and designated as an unsafe smoker, will be supervised during defined smoking times in a designated smoking area...Procedure: 1. Residents who choose to smoke will be evaluated upon admission/re-admission, quarterly, after a change in condition, after incident and as needed to determine if additional adaptive or safety equipment is needed. In addition, the smoking assessment will also determine whether a resident is a safe or unsafe smoker and will be designated as a supervised or unsupervised smoker. 2. Smoking materials will be retained by

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designated center staff...4. Residents assessed as an unsafe smoker and designated as a supervised smoker will be supervised during designated smoking times. 5. Staff will be assigned during designated smoking times to supervise resident smoking..."

The DON (director of nursing) was interviewed on 6/25/19 at 4:50 PM regarding smoking supervision and times. The DON presented smoke times, which were 10 AM, 2 PM, 4 PM, and 7 PM. The DON was asked who is responsible for residents who need supervision that go to smoke at times other than the designated times. The DON stated, "I would say the unit that they live."

On 6/25/19 at 5:10 PM, an interview with Resident #118 was conducted. Resident #118 was sitting in a chair in her room, with a small red bag on her lap. Another resident was present during the interview and was identified as Resident #121 (cognitive score of 15). Resident #118 was asked if staff normally go out with her when she smokes. The resident stated, "No, don't." Resident #121 stated, "She goes out by herself." Resident #118 was asked if she kept her cigarettes in room with her. The resident look bewildered and then shook her head "no", the resident was then asked about the purse she was carrying earlier in the courtyard with the cigarettes and lighter. Resident #118 did not respond. The resident was asked if her smoking materials are kept at the nurse's station. The resident nodded yes.

At approximately 5:20 PM, LPN (Licensed practical nurse) #1 was interviewed and asked about smoking materials for unsafe smokers and

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where are they kept. LPN #1 stated that they have a locked cabinet. LPN #1 was made aware of the observation of Resident #118 earlier with cigarettes and a lighter in her purse. LPN #1 proceeded to the nurse's station and opened the locked cabinet and pulled out a partial pack of cigarettes that had Resident #118's name on them. LPN #1 was asked if that was the only item in the cabinet that belonged to Resident #118 and the LPN stated, "Yes." LPN #1 was asked if the resident was supposed to have the smoking materials in her possession. The LPN stated, "No." While walking to the resident's room, LPN #1 stated, "there she is" [pointing to the smoking area]. Resident #118 was sitting on a bench with the same zipper purse from the first observation at 3:15 PM. The resident was sitting on the bench beside LPN #8. Resident #118 sat there a few minutes and then looked down at the purse unzipped a zipper and put a blue lighter in and zipped it up. LPN #1 stated that she was unaware that the resident had a lighter or cigarettes. LPN #1 stated, "She probably isn't going to smoke, since she knows you are watching."

On 6/25/19 at approximately 6:00 PM, the administrator, DON and CCS (corporate clinical specialist) were made aware of the serious concerns regarding Resident #118 in a meeting with the survey team.

On 6/25/19 at 6:25 PM, LPN #1 was interviewed again. LPN #1 stated, "I just wanted to let you know I got her [Resident #118] lighter from her about 30 minutes ago." LPN #1 was asked if the resident ended up smoking after the observation. LPN #1 stated, "She never did smoke." LPN #1 stated that the resident only had the lighter and

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an empty pack of cigarettes in her purse and maybe she didn't smoke, because she didn't have anymore. LPN #1 stated that she asked the resident where she got the cigarettes and the resident responded that she got them from a man, but did not identify the man. LPN #1 stated that she had absolutely no knowledge that the resident had the smoking materials in her possession and that she told the resident it was unsafe for her to carry the items. LPN #1 stated that the resident gave her purse and contents up willingly.

At 7:00 p.m., on 6/25/19 the administrator, DON, and CCS were called to the conference room. They were informed that the survey team with concurrence from the State Agency had identified immediate jeopardy with subsequent substandard quality of care relating to the lack of supervision to prevent an accident for two residents who were assessed and care planned as unsafe smokers; for failing to implement their policy on smoking for residents smoking at designated times and designated locations; and for failing to ensure smoking materials were stored securely for those resident identified as requiring supervision.

The plan of removal was accepted on 6/25/19 at 8:00 p.m. and contained the following information:

1. The corrective action for the alleged deficient practice will be accomplished by:

Residents #113 had skin assessment performed and no injuries, cigarette holder was purchased for the resident. Care plan to be updated to reflect the new interventions. Resident #118 met with the Executive Director and the Director of Nursing for the facility leadership to explain reason that the

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smoking materials were removed from the resident's possession and stored in accordance with the facility Smoking Policy.

2. Residents with the potential to be affected by alleged deficient practice:

All residents who smoke have the potential to be affected by this alleged deficient practice. The facility Interdisciplinary Team will conduct resident smoking safety assessments on 6/25/19 assessing residents for safe smoking criteria. All residents assessed to be an unsafe smoker will have all smoking materials removed from their possession in accordance with facility smoking policy by 6/26/19. Facility Administrator will conduct town hall meeting with the residents that smoke and review facility smoking policy and consequences for non-compliance.

3. Systemic Changes:

I. The Interdisciplinary Team (Executive Director, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Maintenance, Environmental Service Manager, Human Resources, and Unit Mangers) will be educated by Division Clinical Quality Specialist on, Smoking Policy, resident safe smoking practices, supervision with smoking, and resident non-compliance with smoking policy. Starting 6/25/19, no staff will return to work until they have completed the mandatory education on Facility Smoking policy, safe smoking and supervision, and non-compliance with smoking policy. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will

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be provided prior to starting work. All staff currently working will be educated on Smoking immediately.

II. The center Divisional Executive Director to conduct an ADHOC Quality Assurance Performance Improvement meeting 6/26/19, including the Director of Nursing, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy.

On 6/26/19 the plan of removal was reviewed for evidence verifying the plan had been fully implemented and no residents in the facility were in jeopardy. Information reviewed included updated smoking assessments and care plans for the residents in the survey sample who smoke. Residents were observed smoking only in designated areas, with staff providing supervision to those assessed as unsafe. Smoking materials were observed stored in locked boxes and not with residents assessed as unsafe. Education of staff regarding the smoking policy, supervision of smokers and safe smoking practices, was evidenced by in-service records and staff interviews.

The Immediate Jeopardy was abated on 6/26/19 at 4:05 p.m. with the Scope and Severity lowered to Level II, Pattern.

No further information was provided prior to exit conference.

3. Resident #116 was admitted to the facility on 8/7/13. Diagnoses for this resident included, but

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were not limited to: high blood pressure, history of a stroke with hemiparesis, seizure disorder, anxiety, depression, and a history of falls.

The most current MDS (minimum data set) for Resident #116 was a quarterly assessment dated 6/20/19. This MDS assessed the resident as having a cognitive score of "1", indicating the resident had severe impairment in daily decision making skills. The resident was assessed as requiring extensive assistance for bed mobility/transfers, dressing, toileting, and hygiene.

The resident's annual MDS assessment dated 12/26/18 assessed the resident as a current tobacco user.

The resident was observed on 6/25/19 at 9:30 AM smoking in the courtyard. Two staff members were in the courtyard with other residents. Resident #116 was in close proximity to the staff. Resident #116's cigarette was burned down to the filter when CNA (certified nursing assistant) #2 looked at the resident and stated, "I'll take that." The CNA took it out of the resident's hand and extinguished it.

Resident #116's smoking assessment dated 6/21/19 documented that the resident's decision making skills were not reasonable, nor consistent and the resident's memory and ability to recall was not adequate. The summary of the smoking assessment documented, "Resident can light, manipulate, and extinguish cigarette safely...safe smoker...supervision needed while smoking: None..."

The resident's kardex documented, "...Smoking,

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safe smoker, non-compliant with smoking times..."

The resident's CCP (comprehensive care plan) documented, "...is a smoker...assess for safe smoking...instruct...about smoking risks and hazards...facility policy on smoking, locations, times, safety concerns...observe clothing and skin for signs of cigarette burns...behavior problem refuses foot rest...refuses incontinent care...verbally inappropriate towards staff...noncompliant with smoking policy..." The CCP did not specify what the non-compliance was with the smoking policy, nor were any interventions for non-compliance on the care plan.

The facility smoking policy documented, "Policies and Procedures...10/01/2018...unsafe smoker, will be supervised during defined smoking times in a designated smoking area...residents who choose to smoke will be evaluated upon admission/readmission, quarterly, after a change in condition, after incident and as needed...smoking assessment will also determine...safe or unsafe smoker and will be designated as supervised or unsupervised smoker...Smoking materials will be retained by designated staff...residents assessed as unsafe smoker and designated as a supervised smoker will be supervised during designated smoking times, staff will be assigned during designated smoking times to supervise resident smoking..."

On 6/25/19 at 3:45 PM, the DON, administrator, ADON and corporate clinical specialist were made aware of the safety concerns related to the smoking observation, in addition to the resident's cognitive status, diagnoses (seizure disorder),

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and accuracy of the resident's smoking assessment in a meeting with the survey team.

On 6/25/19 at 6:25 PM, LPN #1 was interviewed. LPN #1 stated that Resident #116 "is probably the safest smoker we have." LPN #1 was made aware of the smoking observation. LPN #1 was asked if she thought Resident #116 would know when to put a cigarette out. LPN #1 stated, "I think he would know, he is safe, I marked him as safe."

On 6/26/19 at 10:30 AM, the ADON was interviewed regarding this resident's CCP. The ADON stated, "As far as I know he [Resident #116] is non-compliant with smoke times." The ADON was asked if the CCP should be more specific and individualized to specify what the non-compliance is, to include interventions to address the non-compliance. The ADON stated, "Yes, it should be more specific and the interventions should be listed."

No further information and/or documentation was presented prior to the exit conference on 6/25/19 at 5:15 PM.

4. Resident #102 was admitted to the facility on 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, intestinal disorder and GERD.

The most current MDS (minimum data set) was a quarterly assessment dated 5/27/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skills. The resident

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was assessed as supervision with set up only for eating/meal consumption.

On 6/25/19 at 7:50 AM, Resident #102 was observed in the dining room on the dementia unit. Resident #102 was in her wheelchair at a table being prompted by LPN (licensed practical nurse) #2 to eat her breakfast.

During this breakfast dining observation, one staff member (LPN # 2) was the only staff person present.

At 7:53 AM, LPN #2 got up, leaving Resident #102 unattended and went to the nurse's station via a "pony" door, closed the door and called the kitchen for the requested items. LPN #2 was gone for 3 minutes. The dining room area was not supervised at all; no staff were present.

At 8:00 AM, LPN #2 got up again and went into the nurses station to call the kitchen for coffee. Again, no supervision was provided in the dining area. LPN #2 returned dining room area at 8:01 AM.

A record review for Resident #102 was completed. Nursing notes documented the following:

5/8/19 12:15 PM "Resident sitting in DR [dining room] eating lunch and became choked. Unable to speak...alerted by CNA [certified nursing assistant]...helmick maneovor [sic] given...start coughing and spit out food...states, "I'm fine..."

5/8/19 1:15 PM "Checked on resident, no distress noted..."

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5/13/19 5:30 PM "...ate supper without difficulty...Speech Referral completed..."

No Speech Referral for this resident was found in the resident's clinical record.

Skilled nursing notes were then reviewed from 5/19/19 through 5/25/19 and documented the following:

5/20/19 "...feeds self with tray set-up..feeds self with cueing from staff..." No information was documented in the swallowing section.

5/21/19 "...Is able to feed self after tray set-up. Needs much encouragement to stay on task...feeds self with cueing and assistance from one staff member..." No information was documented in the swallowing section.

5/22/19 "...feeds self with cueing from staff..." No information was documented in the swallowing section.

5/23/19 "...Is able to feed self after tray set up, needs much encouragement to stay on task..."

5/24/19 "...Requires 1 assist with toileting, ADL's, transfers, and feeding..." No information was documented in the swallowing section.

5/25/19 "...feeds self with tray set-up...requires total dependence with all meals this shift..." No information was documented in the swallowing section.

Nursing notes from 6/4/19 through 6/17/19 documented Resident #102 frequently refused breakfast and lunch.

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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
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The resident's kardex was reviewed and documented, "...independent needs help at times, supervision, cueing, set-up..."

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...[Date initiated: 11/19/18] ADL self-care deficit related to dementia...Eating: ...able to feed herself...[Date initiated: 11/19/18] potential for imbalanced nutrition and fluids related to functional decline, dysphagia, debility, dementia...is dependent upon staff for provision of foods and fluids and feeding at times...Monitor/document/report as needed any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing, Refusing to eat...[Date initiated: 11/19/18]..."

The resident's current physician's orders were reviewed and documented, "...Regular, mechanical soft diet with thin liquids - Put in bowls..."

At approximately 10:00 AM, the Director of Rehab for a sister facility presented a "Rehabilitative Referral" for Resident #102. The Director of Rehab stated that the referral was not completed for this resident.

On 6/25/19 at approximately 3:50 PM, the DON (Director of Nursing), ADON (Assistant Director of Nursing), administrator, and corporate clinical specialist was informed of the above observations and concerns regarding Resident #102 being left unattended during a dining observation..
Concerns were expressed regarding only one staff member being present for supervision, who left Resident #102 on two separate occasions.

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The DON, ADON and administrator stated that they were aware of Resident #102 choking, but did not provide any information regarding why the dementia unit only had one staff member to supervise breakfast on the dementia unit. The DON and administrator were asked for the as worked schedule for 6/25/19 on the dementia unit for day shift.

On 6/25/19 at 5:00 PM, the DON presented a copy of the as worked schedule for the dementia unit. The DON stated that they (the facility) had plenty of staff on the dementia unit. The DON counted and highlighted staff that worked on the dementia unit on 6/25/19 during day shift, which included 3 CNA's (certified nursing assistants), 3 LPN's (Licensed Practical Nurses), a SS (social services) assistant, and LPN #2 (MDS coordinator). The DON could not explain or provide information why only one staff person was supervising in the dining room area for breakfast.

No further information/documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM.
5. Resident #114 was admitted to the facility on 11/26/18 with diagnoses that included cerebrovascular accident (stroke), seizures, coronary artery disease, high blood pressure and depressive disorder. The minimum data set (MDS) dated 6/18/19 assessed Resident #114 with moderately impaired cognitive skills.

On 6/25/19 at 9:10 a.m., Resident #114 was observed smoking independently in the courtyard area without direct supervision. The resident was in the alcove beside the entrance door to the

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courtyard and out of view of a staff member standing at the fountain end of the courtyard.

Resident #114's most recent assessment for safe smoking was dated 6/16/19. This assessment documented assessment criteria related to cognitive status, communication, physical abilities and observed smoking. The summary section indicating if the resident was safe or unsafe to smoke independently was not completed and there was no documentation of what type of supervision, if any, was required for the resident. Further review of the clinical record documented no previous smoking assessments. The resident's admission assessment dated 11/28/19 included a section regarding smoking. This assessment indicated the resident was a smoker and the section indicating if the resident was a safe smoker was documented as, "unknown."

Resident #114's plan of care (revised 2/26/19) documented the resident was a "non-compliant smoker" and non-compliant with safety measures. The plan did not identify the specific non-compliant activities demonstrated by the resident and included no interventions regarding non-compliant smoking.

On 6/25/19 at 2:05 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about Resident #114 smoking without a documented assessment. LPN #3 stated unit managers were responsible for completing smoking assessments at least once per quarter or as needed. LPN #3 stated she performed the assessment dated 6/16/19 and failed to complete the section indicating resident safety and any need for supervision. LPN #3 did not know where Resident #114's previous quarterly assessments

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were located as they were not in the clinical record. LPN #3 stated she did not know why the safe smoking section was not completed on the resident's admission assessment.

On 6/25/19 at 6:20 p.m., the director of nursing (DON) was interviewed about any previous assessments regarding Resident #114's smoking. The DON stated she did not find any other smoking assessments for Resident #114. The DON stated she did not know why the resident did not have quarterly smoking assessments completed.

The facility's policy titled Smoking - Supervised and Unsupervised (effective 10/1/18) documented, "...Residents who choose to smoke will be evaluated upon admission/re-admission, quarterly, after a change in condition, after incident and as needed to determine if additional adaptive or safety equipment is needed. In addition, the smoking assessment will also determine whether a resident is a safe or unsafe smoker and will be designated as a supervised or unsupervised smoker..."

This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.

6. Resident #119 was admitted to the facility on 1/16/17 with a re-admission on 6/14/19. Diagnoses for Resident #119 included paranoid personality, schizophrenia, neuropathy, peripheral vascular disease, psychosis and cerebrovascular disease. The minimum data set (MDS) dated 4/9/19 assessed Resident #119 as cognitively intact.

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On 6/25/19 at 9:53 a.m., Resident #119 was observed independently smoking at the end of the sidewalk adjacent to the parking lot at the front of the building. There were signs posted on the building wall beside the walkway stating no smoking was allowed in this area. Resident #119 was interviewed at this time about smoking outside of the facility in a non-designated smoking area. Resident #119 stated he frequently came outside to the front walk area to smoke. Resident #119 stated he liked the outside area at the front of the building better than the designated courtyard. Resident #119 stated staff members had told him before not to smoke in the outside sidewalk area. Resident #119 stated, "The air is better out here. I just like to sit out here." Resident #119 stated if smoking on the sidewalk was a problem then he would sign out and go to the street to smoke.

Resident #119's most recent assessment for safe smoking was 6/14/19 and documented the resident was a safe smoker requiring no supervision.

The resident's plan of care (revised 4/10/19) listed the resident was a smoker. Care plan interventions listed to prevent injury from unsafe smoking included instructions on risks/hazards of smoking, instructions of facility smoking policy including locations and times to smoke, monitoring resident for safe smoking and observe resident's clothing and skin for signs of cigarette burns. Listed under resident behaviors was "non-compliant with smoking policy." The plan did not identify the specific non-compliant activities demonstrated by the resident and included no interventions regarding non-compliant smoking.

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On 6/26/19 at 8:10 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #119 smoking in a no smoking area. LPN #1 stated the resident often smoked "out front" on the sidewalk area. LPN #2 stated Resident #119 frequently resisted care and was at times difficult to re-direct. LPN #2 stated staff members were aware the resident smoked outside in a non-smoking area. When asked what interventions were implemented to ensure he was smoking in a designated area, LPN #1 stated they tried to direct Resident #119 to the designated smoking area in the courtyard but he was not cooperative with re-direction. LPN #1 stated, "He [Resident #119] is going to do what he wants."

The facility's policy titled Smoking - Supervised and Unsupervised (effective 10/1/18) documented, "...will provide a safe, dedicated smoking area for residents...Residents, who have been assessed and designated as a safe smoker, will be allowed to freely smoke in the area designated for resident smoking....If a resident is assessed as a safe smoker and designated as an unsupervised smoker then they are granted the right to smoke at their convenience in a designated smoking area..."

This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.
7. Resident #108 was admitted to the facility on 6/21/17 with the most recent readmission on 10/16/17. Diagnosis for Resident #108 included anxiety disorder, cardiac murmur, muscle weakness, polyosteoarthritis, depression, osteoporosis, dementia with behavioral disturbance, hypertension, and chronic

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obstructive pulmonary disease. The most recent MDS (minimum data set) dated 6/20/19 assessed Resident #108 with severely impaired cognitive skills.

On 6/24/19 beginning at approximately 10:50 a.m., Resident #108 was observed on the dementia unit at the end of the hall near the entrance doors, sitting in her wheelchair facing the door (facing away from the nurses station). At 11:15 a.m. Resident #108 remained in the same location and was asleep in her wheelchair; no staff were present in the area. Resident #108 remained asleep in her wheelchair in the same location until 11:32 a.m. when she woke up, turned herself around in her wheelchair so that she faced the nurses station, and fell back to sleep. The resident remained asleep in her wheelchair in the same location until 11:39 a.m. when a staff member moved her towards the nurses station. For the 25 minutes Resident #108 was observed asleep in her wheelchair, she was not supervised, moved, or made an offer to go to bed.

Review of the clinical record evidenced that on 6/13/19 Resident #108 fell from her wheelchair. Nursing notes documented that Resident #108 was observed on her knees, face down on the floor in front of her wheelchair in the dining hall. When asked what happened, she stated "I fell asleep."

Resident #108's current care plan dated 10/31/18 with a goal target date of 7/15/19, included a focus area that Resident #108 had actual falls related to poor balance and unsteady gait. An intervention added after a fall on 3/31/19 included "...staff educated if she is falling asleep in

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wheelchair, offer PERIODS OF REST as she allows..."

On 6/25/19 at 8:55 a.m., Resident #108 was observed in the dining room at a table with 3 other residents. A staff member was sitting at another table next to the window with a view of the room. Resident #108 was asleep in her wheelchair.

At 9:26 a.m. CNA #10 who stated she knew Resident #108, was interviewed about what staff do to keep Resident #108 safe and from falling. CNA #10 stated, "...try to keep her in the dining room, try to stick with her, fall matt beside her bed, stay pretty close to her, if she is extremely sleepy will put her back to bed..."

During the end of day meeting on 6/25/19 with the DON (director of nursing) and the Administrator, concerns regarding the 25 minute observation of Resident #108 asleep in her wheelchair without supervision were discussed. The DON and Administrator were made aware that Resident #108 had fallen asleep in her wheelchair and had a fall in the dining room 12 days prior, and her care plan indicated that staff were to offer periods of rest when she was falling asleep in her wheelchair as a safety intervention to prevent falls. For 25 minutes Resident #108 was asleep in her wheelchair at the end of the unit hall, without staff supervision, and not offered to be put to bed.

No further information was provided prior to the exit conference on 6/26/19.

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F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2)	F 741		8/6/19

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F 741	Continued From page 56 §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure sufficient staff to provide direct services and assure safety to meet the needs of one of 20 residents in the survey sample (Resident #102). Findings include: Resident #102 was admitted to the facility on	F 741	741 Resident #102 is being supervised during dining service and sufficient staff are provided to the dementia unit to ensure more than 1 person is present during meal service. All residents have the potential to be	

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F 741	Continued From page 57 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, intestinal disorder and GERD. The most current MDS (minimum data set) was a quarterly assessment dated 5/27/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skills. The resident was also assessed as requiring limited assistance of one with bed mobility, transfers, and ambulation. The resident was assessed as supervision with set up only for eating/meal consumption. The resident's mode of transportation was a wheelchair. On 6/25/19 at 7:50 AM, Resident #102 was observed in the dining room on the dementia unit. Resident #102 was in her wheelchair at a table being prompted by LPN (licensed practical nurse) #2 to eat her breakfast. During this breakfast dining observation, one staff member (LPN # 2) was the only staff person present. At 7:53 AM, LPN #2 got up, leaving Resident #102 unattended and went to the nurse's station via a "pony" door, closed the door and called the kitchen for the requested items. LPN #2 was gone for 3 minutes. The dining room area was not supervised at all; no staff were present. At 8:00 AM, LPN #2 got up again and went into the nurses station to call the kitchen for coffee. Again, no supervision was provided in the dining area. LPN #2 returned dining room area at 8:01	F 741	affected. Staff schedules will reflect assignments and sufficient staff will be provided in the dementia unit to ensure more than 1 person is present during meal service. Nursing staff to include staff working on the dementia unit will be educated by the SDC on caring for residents with mental disorders and implementing non-pharmacological disorders by 8/6/2019. The staffing coordinator will be educated on sufficient staffing for the dementia unit by 8/6/2019. The ED, DON, ADON, HRC, Staffing Coordinator will meet weekly to review staffing schedule to ensure sufficient staff for 8 weeks. The DON, ADON, ED, UM, and manager on duty will conduct quality monitoring for sufficient staff during 2 meals per day on the dementia unit 5x per week for 2 weeks, 3x per week for 2 weeks, weekly for 4 weeks then monthly for 2 months. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of Compliance: 8/6/2019	

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AM.

A record review for Resident #102 was completed. Nursing notes documented the following:

5/8/19 12:15 PM "Resident sitting in DR [dining room] eating lunch and became choked. Unable to speak...alerted by CNA [certified nursing assistant]...helmick maneovor [sic] given...start coughing and spit out food...states, "I'm fine..."

5/8/19 1:15 PM "Checked on resident, no distress noted..."

5/13/19 5:30 PM "...ate supper without difficulty...Speech Referral completed..."

No Speech Referral for this resident was found in the resident's clinical record.

Nursing notes from 6/4/19 through 6/17/19 documented Resident #102 frequently refused breakfast and lunch.

The resident's kardex was reviewed and documented, "...independent needs help at times, supervision, set-up..."

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...[Date initiated: 11/19/18] ADL self-care deficit related to dementia...Eating: ...able to feed herself...[Date initiated: 11/19/18] potential for imbalanced nutrition and fluids related to functional decline, dysphagia, debility, dementia...is dependent upon staff for provision of foods and fluids and feeding at times...Monitor/document/report as needed any signs/symptoms of dysphagia: pocketing,

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choking, coughing, drooling, holding food in mouth. Several attempts at swallowing, Refusing to eat...[Date initiated: 11/19/18]..."

The resident's current physician's orders were reviewed and documented, "...Regular, mechanical soft diet with thin liquids - Put in bowls..."

At approximately 10:00 AM, the Director of Rehab for a sister facility presented a "Rehabilitative Referral" for Resident #102. The Director of Rehab stated that the referral was not completed for this resident.

On 6/25/19 at approximately 3:50 PM, the DON (Director of Nursing), ADON (Assistant Director of Nursing), administrator, and corporate clinical specialist were informed of the above observations and concerns regarding Resident #102 being left unattended during a dining observation, a resident with a known episode of choking, along with 21 other residents on the dementia unit that only had one staff member for supervision, who left the residents on two separate occasions with no supervision.

The DON, ADON and administrator stated that they were aware of Resident #102 choking, but did not provide any information regarding why the resident did not have a speech therapy consult/screening completed, or why the resident's CCP was not updated, or why the the dementia unit only had one staff member to supervise 22 residents during breakfast. The DON and administrator were asked for the as worked schedule for 6/25/19 on the dementia unit for day shift.

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F 741	Continued From page 60 On 6/25/19 at 5:00 PM, the DON presented a copy of the as worked schedule for the dementia unit. The DON stated that the facility had plenty of staff on the dementia unit and counted and highlighted staff that worked on the dementia unit on 6/25/19 during day shift, which included 3 CNA's (certified nursing assistants), 3 LPN's, a social services assistant, and LPN #2 (MDS coordinator). The DON could not explain or provide information as to why only one staff person was supervising 22 residents in the dining room area for breakfast on the dementia unit. No further information/documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM to evidence that the facility staff had sufficient staff to assure safe on the dementia unit.	F 741		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from	F 825		8/6/19

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F 825

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participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a speech therapy evaluation was completed for one of 20 residents in the survey sample, Resident #102.

Findings include:

Resident #102 was admitted to the facility on 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, intestinal disorder and GERD.

The most current MDS (minimum data set) was a quarterly assessment dated 5/27/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skills. The resident was assessed as supervision with set up only for eating/meal consumption.

On 6/25/19 at 7:50 AM, Resident #102 was observed in the dining room on the dementia unit. The resident was in her wheelchair at a table being prompted by LPN (licensed practical nurse) #2 to eat her breakfast.

A record review for Resident #102 was completed. Nursing notes documented the following:

5/8/19 12:15 PM "Resident sitting in DR [dining room] eating lunch and became choked. Unable

F 825

F 825

Resident #102 was evaluated by speech therapy on 7/23/2019 with no new orders.

All residents have the potential to be affected. A quality review will be completed by ADON on all residents who have had an speech evaluation ordered in the past 30 days to ensure resident provided with speech therapy if indicated or documentation if not indicated and comprehensive care plan updated to reflect evaluation by 8/2/2019.

The Operations Area Director for our therapy department will educate the DOR and speech therapists on evaluating per MD order and documenting results of evaluation by 8/6/2019.

The DOR will conduct quality monitoring on 5 residents per week requiring speech therapy services to ensure evaluations were completed, documented and indications followed for 8 weeks. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary

Allegation of compliance: 8/6/2019

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F 825	Continued From page 62	F 825		

to speak...alerted by CNA [certified nursing assistant]...helmick maneovor [sic] given...start coughing and spit out food...states, "I'm fine..."

5/8/19 1:15 PM "Checked on resident, no distress noted..."

5/13/19 5:30 PM "...ate supper without difficulty...Speech Referral completed..."

No Speech Therapy referral for this resident was found in the resident's clinical record.

Skilled nursing notes were then reviewed from 5/19/19 through 5/25/19 and documented the following:

5/20/19 "...feeds self with tray set-up..feeds self with cueing from staff..." No information was documented in the swallowing section.

5/21/19 "...Is able to feed self after tray set-up. Needs much encouragement to stay on task...feeds self with cueing and assistance from one staff member..." No information was documented in the swallowing section.

5/22/19 "...feeds self with cueing from staff..." No information was documented in the swallowing section.

5/23/19 "...Is able to feed self after tray set up, needs much encouragement to stay on task..."

5/24/19 "...Requires 1 assist with toileting, ADL's, transfers, and feeding..." No information was documented in the swallowing section.

5/25/19 "...feeds self with tray set-up...requires

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F 825		F 825		

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total dependence with all meals this shift..." No information was documented in the swallowing section.

Nursing notes from 6/4/19 through 6/17/19 documented Resident #102 frequently refused breakfast and lunch.

The resident's kardex was reviewed and documented, "...independent needs help at times, supervision, cueing, set-up..."

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...[Date initiated: 11/19/18] ADL self-care deficit related to dementia...Eating: ...able to feed herself...[Date initiated: 11/19/18] potential for imbalanced nutrition and fluids related to functional decline, dysphagia, debility, dementia...is dependent upon staff for provision of foods and fluids and feeding at times...Monitor/document/report as needed any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing, Refusing to eat...[Date initiated: 11/19/18]..."

The resident's current physician's orders were reviewed and documented, "...Regular, mechanical soft diet with thin liquids - Put in bowls..."

On 06/25/19 at at 9:20 AM, the ST (Speech Therapist) #1 was interviewed regarding Resident #102. ST #1 stated that she did not know this resident and was not familiar with this resident as she was new and had only been here for approximately 3 weeks. ST #1 stated that she was the only ST here at this time and stated that the other ST (#2) was on vacation, as of June 21.

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ST #1 was made aware of the concerns with Resident #102 choking and was asked about the ST referral that was referenced in the nursing notes. ST #1 looked in the computer and stated that she saw dates for the choking episode, but did not see any information regarding it. The ST #1 stated that the date in the computer was 5/10/19 (two days after the choking episode), but there was no documentation/information regarding it.

ST #1 then began looking in binders for Speech therapy "screens" and stated that there was no information anywhere regarding Resident #102. The ST was asked for assistance in locating any information for this resident regarding the above.

At approximately 10:00 AM, the Director of Rehab for a sister facility presented a "Rehabilitative Referral" for Resident #102. The referral documented, "...Resident observations [all were blank]...Comments: Choked on a piece of food at lunch. Heimlich remover [sic] performed. Signature of LPN #2 [person making referral/date] 5/8/19...Outcome of Referral:...Follow-up: Eval attempted. Pt [patient] refused any p.o. [sic] [by mouth] intake. Signature of ST #2 [Therapist's signature] [date reviewed: 5/10/19]."

On 6/25/19 at approximately 3:50 PM, the DON (Director of Nursing), ADON (Assistant Director of Nursing), administrator, and corporate clinical specialist was informed of the above concerns in a meeting with the survey team.

The DON, ADON and administrator stated that they were aware of Resident #102 choking, but did not provide any information regarding why the

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F 825	Continued From page 65 resident did not have a ST consult/screening completed or why the resident's CCP was not updated to reflect the above information. No further information/documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM.	F 825		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility administrator failed to provide effective administration in a manner to maintain the highest practicable well-being of each resident for 5 of 20 residents in the survey sample. The administrator failed to ensure two residents assessed as unsafe smokers were supervised, failed to ensure smoking materials for unsafe smokers were stored safe and secure, and failed to ensure individualized care plans for the unsafe and non-compliant smokers. Findings include: On 6/26/19 at 1:30 PM, during a review of the facility's QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) program, the	F 835	F 835 The residents assessed as unsafe smokers are now supervised by center staff during smoking sessions. Smoking material has been secured at the nurse□s station and is disseminated only during supervised smoking sessions. Care plans, for smokers assessed as unsafe, were reviewed and updated to reflect unsafe or non-compliant smoking. Administrator educated by the Regional Director of Clinical Services on regulation F 926 Smoking Policies and regulation F 689 guidance for resident smoking by 7/26/2019. All residents have the potential to be affected. The DON and ED will conduct a quality review of all resident smokers to	8/6/19

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F 835	Continued From page 66 administrator was interviewed regarding supervision of residents, specifically as supervision was cited at a harm level deficiency on the previous survey. The administrator stated, "...it was an oversight really, our primary focus was on falls and specific cited deficiencies, it was our mistake." The administrator was then asked about unsafe smokers, non-compliant smokers and supervision of unsafe smokers. The administrator stated that the facility revised their smoking policy in October of 2018 and that the change came from corporate. The administrator stated that the facility had so many safe smokers and the change in the policy was to provide more liberalization for safe smokers and that they [facility] were looking at it as more of a right than a privilege. The administrator stated, "We have had knowledge for a while now of the non-compliance, we'd just educate on safe smoking and the policy and that's been ongoing. We'd address when we'd hear about it [non-compliance/unsafe smoking], but didn't have a process to drill down to fix it, we'd address by continually putting out fires. We [facility] need to look at further recourse as far as paraphernalia." No further information and/or documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM.	F 835	review individual smoking assessments to re-identify unsafe smokers, review unsafe smokers care plans to ensure smoking safety protocols are in place, documented and on the residents Kardex by 8/2/2019. The DON and ED will additionally, review safe smokers care plan for compliance status, and for resident smokers identified as non-compliant ensure specific non-compliance is documented by 8/2/2019. The RDCS will educate the leadership team on regulation F 926 Smoking Policies and regulation F 689 guidance to surveyors for resident smoking. Education will also encompass supervision requirement for staff supervising unsafe smokers during designated smoking times. Mailboxes purchased for smoking materials to be left locked and secured in the designated smoking area by 8/6/2019. The ED will conduct quality monitoring on the facilities smoking practices weekly for 8 weeks. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of compliance: 8/6/2019	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		8/6/19

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F 842	Continued From page 67	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

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record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, facility staff failed to ensure a complete and accurate clinical record for one of 20 residents in the survey sample, Resident #120. The Social Worker (SW) failed to document a psychosocial assessment in the clinical record for Resident #120.

Findings included:

Resident #120 was originally admitted to the facility on 03/07/2017 and readmitted on 06/09/2019 with diagnoses including, but not limited to: Parkinson's Disease, Depression and

F 842

F 842

Resident # 120’s psychosocial evaluation was documented as a late entry and placed in the medical record on 6/26/2019.

All residents have the potential to be affected. The ADON will conduct a quality review on residents requiring psychosocial documentation over the last 30 days to ensure entries were made timely into the clinical record. Quality review conducted by 7/26/2019.

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Gastroesophageal Reflux Disease (GERD).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/12/2019. Resident #120 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

The facility Plan of Correction (POC) was reviewed on 06/26/2019 at 1:00 p.m. Included in the plan for "Medically Related Social Services" was a record review for Resident #120, completed on 06/07/19 by the Administrator. The review indicated Resident #120 had not had a psychosocial assessment completed.

The DON (director of nursing) was interviewed on 06/26/19 at 2:00 p.m. regarding the psychosocial assessment. No assessment was located in the clinical record.

The DON and SW came to the conference room at 2:30 p.m. The DON stated, "She [SW] did the assessment on 6/12/19 of Resident #120. It is written in her personal notebook, but was not documented in the clinical record until 2:08 p.m. today as a late entry." When asked why the assessment was not documented in the clinical record the DON stated, "Since you all were here the process has changed and we have her [SW] looking at FRI's [facility reported incidents], complaints and everything else. It is about twelve a day. She has done the assessment. It is written in her notebook, but she just documented in the record." The SW stated, "I have it here with an asterisk to chart. I guess I got pulled away or I just overlooked it to put in the record. I carry this notebook with me all the time and just take notes as I go." A copy of the notebook entry

F 842

Clinical staff to include Social Services and MDSC to be educated by the SDC on requirement that each medial record must be maintained on each resident and each record must be complete, accurately documented, readily accessible and systematically organized by 8/6/2019.

The ED to conduct quality monitoring on 5 residents per week for 8 weeks to ensure psychosocial assessments are entered accurately and timely in the clinical record. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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F 842	Continued From page 70 and late entry progress note were received from the DON. No further information was provided to the survey team prior to the exit conference on 06/26/2019.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and 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 staff interview and facility document review, the QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) committee failed to develop and implement an appropriate plan of action for an identified quality deficiency regarding smoking. Findings included: On 6/26/19 at 1:30 PM, the administrator was interviewed regarding the facility's QAA/QAPI committee. The administrator was asked about supervision and smoking. The administrator stated that they identify issues a variety of ways and determine which will be addressed by the committee to develop a plan of action. The administrator was asked specifically about supervision and smoking. The administrator stated that they (facility) were previously cited for supervision on the survey prior to this one (harm	F 867	F 867 Facility QAPI committee will meet to analyze smoking practices and identified quality deficiencies regarding smoking and develop a performance improvement plan to develop an appropriate plan of action by 7/26/2019. The committees findings will be reviewed by RVPO/RDCS/Divisional Clinical Quality Specialist to ensure QAPI committee identifies and addresses the quality deficiency appropriately. All residents have the potential to be affected. No residents were negatively affected. The QAPI committee will be educated by the RDCS on the facilities QAPI policies, process and tools developed to identify, plan, track and measure areas identified	8/6/19

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F 867	Continued From page 71 level deficiency), and stated that the facility had a focus on falls in relation to supervision, not necessarily smoking and further stated, "It was an oversight on our part really." The administrator stated that the facility staff were aware of the issues surrounding smoking, unsafe smoking and supervision, and non-compliance by some of the smokers. The administrator stated that the facility knew of the concerns, but did not take it to QA for a plan of action. The administrator stated that the facility would address the issues as they would arise, but again stated that they did not develop a formal plan of action to address and fix the problems with smoking concerns. The administrator stated that the facility would basically educate the residents on safe smoking and on the policy with no additional plans and that process was ongoing. The administrator stated, "We were basically putting out fires [addressing issues when they came up]." No further information and/or documentation was presented prior to the exit conference on 6/26/19 at 5:15 PM, to evidence that the QAA/QAPI committee developed or implemented an appropriate or effective action plan for safe smoking.	F 867	as needing improvement by 8/6/2019. Monthly QAPI minutes will be provided to the RVPO or RDCS to conduct quality monitoring on the facility committees ability to develop and implement appropriate plans of action to correct identified quality deficiencies monthly for 3 months. Quality monitoring schedule modified based on findings. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of compliance: 8/6/2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		8/6/19

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ENVOY OF STAUNTON, LLC	**512 HOUSTON STREET STAUNTON, VA 24402**

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F 880	Continued From page 72	F 880		

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

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F 880	Continued From page 73 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices for one of 20 residents in the survey sample. Hand hygiene was not performed after performing perineal care for Resident #101. The findings include: Resident #101 was admitted to the facility on 8/30/18 with diagnoses that included intellectual disability, blindness, diabetes, muscle weakness, failure to thrive and high blood pressure. The minimum data set (MDS) dated 6/7/19 assessed Resident #101 with severely impaired cognitive skills and as requiring total assistance of one person for hygiene. On 6/24/19 at 2:55 p.m., certified nurses' aide (CNA) #4 was observed providing perineal care	F 880	F 880 Resident #101 assessed and found to be in normal clinical condition without indication of negative effects or infection from observation on 6/24/2019 with CNA #4. CNA #4 will be provided education on infection control hand hygiene policy with a competency to follow to demonstrate knowledge by 7/26/2019. All residents have the potential to be affected. The SDC will conduct a quality review of handwashing with clinical staff members to ensure infection control practices are followed by 8/2/2019. The SDC will educate nursing staff on hand hygiene policy following perineal care to follow with competency to	

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F 880	Continued From page 74 to Resident #101. CNA #4 had gloves on and washed the resident's perineal area with a wet washcloth. CNA #4 dried the resident and placed the washcloth and towel into a plastic bag. Without removing her gloves or performing hand hygiene, CNA #4 placed an incontinence brief on the resident and then assisted the resident with putting on a shirt and pants. CNA #4 then removed her gloves and without performing hand hygiene, put on a new pair of gloves. CNA #4 then secured the resident's call bell to the bed covers, raised the bed rail and put the remaining dirty clothing items into a plastic bag. CNA #4 removed her gloves, tied up the dirty laundry bags and adjusted the temperature on the air conditioning unit at the request of the roommate. CNA #4 left the room, discarded the dirty clothing items in the soiled utility room, got a clean towel from the laundry cart and handed the towel to another staff member. CNA #4 then retrieved her tablet and began entering information. CNA #4 performed no hand hygiene after Resident #101's perineal care or after removing gloves following the care observation. On 6/24/19 at 3:10 p.m., CNA #4 was interviewed about hand hygiene during and after the perineal care observed with Resident #101. CNA #4 stated she was supposed to wash hands after personal care for residents. Concerning handwashing after care with Resident #101, CNA #4 stated, "I was getting ready to do that [wash hands]." On 6/25/19 at 10:10 a.m., the licensed practical nurse unit manager (LPN #3) was interviewed about the lack of hand hygiene during and after personal care with Resident #101. LPN #3 stated staff members were required to wash hands after	F 880	demonstrate knowledge by 8/6/2019. The SDC will conduct quality monitoring of 5 staff members per week for 8 weeks for proper hand hygiene following care. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of compliance: 8/6/2019	

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F 880	Continued From page 75 performing direct care with residents. The facility's infection control policy titled Hand Hygiene (revised 5/10/19) documented, "The CDC [center for disease control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel)... To reduce the spread of germs in the healthcare setting..." This policy stated, "Hand hygiene should be performed...Before and after patient care...After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings...When hands are moved from a contaminated-body site to a clean body site during patient care...After glove removal..." This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 6/25/19 at 3:20 p.m.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure an effective pest control program. Flies were observed in a resident room on the second floor, in the hallways and dining area on the second floor, and in a resident room on the 3rd floor dementia unit. The findings include:	F 925	F 925 Resident # 107, Resident # 103, Resident #113 rooms, units 2 NW, 3 NW and the courtyard will be treated by facilities pest control vendor. In addition new air curtains were purchased for the courtyard and will be installed by 7/31/2019.	8/6/19

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On 6/25/19 at 8:15 AM, Resident #107 was being interviewed in his room. Resident #107 most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/7/19 indicated Resident #107 was cognitively intact with a score of 15.

During the interview multiple flies were observed on the window, bed, coffee cup and over bed table. When asked about the flies, Resident #107 stated they are all over the place.

During the conversation a certified nursing assistant (identified as CNA #1) came into Resident #107's room to ask Resident #107 if he was aware of a scheduled appointment. Prior to CNA #1 leaving the room, CNA #1 asked Resident #107 if he needed anything and asked if Resident #107 wanted a fly swatter, Resident #107 agreed to a fly swatter.

After the interview was completed, observations were made throughout the second floor (2 New West) where Resident #107 resided. Multiple flies were observed in the hallways and in the dining area adjacent to the outside courtyard.

On 6/25/19 at 8:40 AM, CNA #1 was interviewed about the flies. CNA #1 stated that the flies enter from the courtyard. CNA #1 stated that two of the doors are not automated and if residents are trying to come in or go out to the courtyard by themselves, they have a hard time getting through the doors if they are in a wheelchair, which allows the flies to enter the building. CNA #1 also stated that there is one automated door with an air curtain on the opposite side of the courtyard, but only one of the manual doors has an air curtain which is sometimes cut off or turned

F 925

All residents have the potential to be affected. The Executive Director will conduct a quality review of the facility to determine if any additional areas need to be treated for flies by 8/2/2019.

The Maintenance Director will be educated by the Executive Director on facility's pest control policy by 8/6/2019.

The Maintenance Director will conduct quality monitoring of the center daily 5x per week for 2 weeks, 3x per week for 2 weeks, weekly for 4 weeks then monthly for 2 months to monitor for presence of pests. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary.

Allegation of compliance: 8/6/2019

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down to where not much air is blowing down.

Observations were made of all 3 doors leading to the courtyard. The automated door had a strong air flow to the air curtain, one of the manual doors air curtain had very low air flow and the other manual door did not have an air curtain.

On 6/25/19 at 9:10 AM, the maintenance director (other staff, OS #1) was interviewed regarding flies. OS #1 stated that he felt that there where too many doors leading to the courtyard which allowed flies to enter the facility. When asked about the air curtain being turned down, OS #1 stated that he has observed the air flow being low at times going through one of the manual doors and he would adjust the air level to blow more air.

On 6/25/19 at 9:30 AM, the housekeeping director (OS #2) was interviewed. OS #2 stated that residents attempt to go in and out of the manual doors by themselves and have the doors open for extended periods of time. Also residents take food and drinks out to the courtyard spilling or dropping food which also contributes to the fly problem. OS #2 went onto say that the residents take bread out to feed the birds and throw it on the ground (this was also observed during the survey).

On 6/24/19 at 2:50 PM, Resident #103 was observed seated in a wheelchair in her room on the third floor dementia unit. The resident had multiple skin lesions and scabbed areas on the cheeks of her face and her nose. A fly was observed near the resident's face, continuing to land on her face and nose. The resident swatted at the fly multiple times with her hands as the fly continued to hover around her face and head.

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F 925	Continued From page 78 On 6/24/19 at 3:55 p.m., Resident #113 was observed in her room with a fly continuing to hover around her head and face. On 6/25/19 at 7:45 a.m., Resident #103 was in bed. A fly was observed near the center of the room. On 6/25/19 at 7:40 a.m., a fly was observed in the hallway near room 332 on the third floor. Pest control extermination reports were reviewed for the month of May 2019 (last report available). The report indicated that glue traps for flies were replaced (due to being 25 % full) in the kitchen and hallways. The report did not indicate pest control applied to the courtyard. On 6/25/19 at 3:20 PM, the above information was presented to the administrator, director of nursing and corporate clinical director. The corporate clinical director stated the facility would be looking into possibly making the manual doors automated. No other information was provided prior to exit conference on 6/26/19.	F 925		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 947		8/6/19

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§483.95(g)(2) Include dementia management training and resident abuse prevention training.

§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, the facility failed to ensure continuing nurse aide education of 12 hours per year for 37 of 54 nurse aides.

The findings include:

Nurse aide continued competence program was reviewed on 6/26/19. An education calendar evidenced monthly completion dates for specific inservices along with required inservices that would be provided each month by the facility.

On 6/26/19 at 11:00 AM, the educational nurse (RN #2) was interviewed regarding evidence that nurse aides received the required inservices and had a minimal amount of training hours. RN #2 stated that she had only been at the facility for about a month and had been trying to get all the nurses aides up to date on the educational hours and required inservices, but would pull together what she could find.

On 6/26/19 at 11:45 AM, the Corporate Clinical

F 947

F 947

The facility will ensure that for those certified nurse aides who have been employed by the center for a minimum of a year or more will receive the required 12 hours of yearly education by AOC date or they will not be allowed to work until completed.

All residents have the potential to be affected. A quality review will be completed by the DON on yearly CNA training calendar to ensure that scheduled calendar meets requirements of 12 hours annually, addresses the care of the cognitively impaired, dementia training and abuse training by 8/2/2019.

The DON and SDC will be educated by RDCS on the requirements of In-Service Training for Nurse Aides by 7/26/2019. The SDC will educate nurse aides of the training requirement, yearly schedule, and

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F 947	Continued From page 80 Director (CCD) presented documentation of education provided for approximately 8 nurse aides. The CCD stated that the software system for education has many facets and can be hard to navigate to be able to evidence that nurse aides had received the required amount of educational hours, and stated that an educational nurse was recently hired to ensure the aides were getting the required hours and inservices. The CCD stated that he was aware of the concern with the educational software system and also aware that nurse aides have not met the required amount of educational hours, but have been educated on the required inservices such as abuse/neglect. The CCD stated that he was able to identify through the software program that 31% (17) of the nurse aides were in compliance with the educational hours. A list of aides working at the facility indicated there are 54 nurse aides employed. No other information was presented prior to exit conference on 6/26/19.	F 947	their responsibility to attend trainings which without will make them ineligible to work until the training is completed by 8/6/2019. The HRC will conduct quality monitoring of nurse aid in-service training weekly to demonstrate attendance for 2 months then monthly for 2 months. Findings will be reported to the Quality Improvement Committee team monthly and the plan will be revised as necessary. Allegation of compliance: 8/6/2019	