STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELMONT NURSING AND REHAB CTR	110 BELMONT RD MADISON, WI 53714

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0559 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure each resident's guardian received notice before a room change occurred within the facility for 1 of 3 Residents (R1) out of a total sample of 8 Residents. R1 was moved from the Birch hall to the Cedar hall without his guardian's consent. This is evidenced by: Facility Policy entitled 'Transferring a Resident within the Facility,' dated 4/1/08, states, in part: . The facility will move the resident and their belongings safely and with the least possible confusion for the resident. Whenever a resident is transferred from one room to another within the facility, a notice of transfer must be given to resident (sic) and/or family prior to the move, according to state law. Procedure: 1. Notify and explain the reason for transfer to the resident and/or family or responsible party of the resident. 2. Obtain the resident's/DPOA's (durable power of attorney) agreement to the transfer. Document the approval in the nurse's notes and/or on a facility-specific form . R1 was admitted on [DATE], with [DIAGNOSES REDACTED]. A list of Residents with a recent room change indicated that R1 was moved on 5/7/20 from the Birch hall onto the Cedar hall. Surveyor was not provided documentation to show R1's Guardian, gave consent for R1 to be moved on 5/7/20. On 5/21/20 at 2:09 PM, Surveyor interviewed SW C (Social Worker) regarding R1's room change. SW C indicated that they moved R1 to Cedar due to going out the door on Birch and needing to move to a long-term care room. SW C indicated they had a private room available to move R1 into. SW C indicated that she called R1's Guardian and left a voice mail. SW C indicated that R1's Guardian left a voicemail, which she herself did not listen to. SW C indicated there was a miscommunication as R1's Guardian wanted to talk prior to a room move. SW C indicated her assistant listened to the message and indicated the room change was a go. SW C indicated that R1's Guardian was not happy with the move and going forward will call back to clarify before moving. SW C indicated that R1 was not moved due to COVID-19 but due to exiting the door on the Birch hall. SW C agreed the guardian should've consented prior to the move occuring. On 5/21/20 at 3:59 PM, Surveyor interviewed Guardian D regarding R1's room change. Guardian D indicated that she does not agree with R1 moving rooms due to other exit doors near his new room. Guardian D indicated that R1 has the ability to steal food with the kitchen, being right near his room. Guardian D indicated she did not give permission to move R1 before he was moved.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each Resident received adequate supervision to prevent accidents for 2 of 5 Residents (R1 & R2) reviewed for accidents and/or smoking out of a total sample of 8 Residents. R1 is protectively placed and has a guardian. He is described as being impulsive, having poor safety awareness and not able to make sound decisions. R1 left the facility unsupervised on multiple occasions to smoke, go for a walk or go to the gas station without the knowledge of facility staff. After the second elopement on 3/12/20, no long-term plan was put in place to supervise R1's whereabouts. When a wanderguard bracelet was added 5/1/20, there was no evidence R1's wandering bracelet was checked for functioning or placement. R1's care plan was not updated timely. R1 was not placed in the wander guard book after the wandering bracelet was placed. R1 did not return smoking materials after smoking and was found smoking in his room. R2 is a known smoker, who was found smoking in his room upon re-admission. The Facility's failure to provide supervision of a protectively placed resident who has left the facity on multiple occasions, failure to prevent and assess residents who are at risk for elopement, failure to ensure wanderguard equipment is in functioning order, failure to appropriately assess a residents' risk for injury related to smoking and not ensuring smoking materials are contained to prevent injury created a finding of immediate jeopardy that began on 3/12/20. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 5/26/20 at 2:00 PM. The immediate jeopardy was removed on 6/2/20. However the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: The Facility's Policy entitled 'Elopement/Missing Resident,' dated April 2009, states, in part: . It is the facility's policy to implement all possible measures to protect/minimize any resident who attempts to elope. Definition: Elopement, for purposes of this policy and procedure, is defined as a situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety needs, and therefore at risk for injury outside the confines of the facility, has left the facility without the knowledge of staff. Procedure: 1 .Residents will be re-assessed for elopement risk if the resident makes attempts to elope and/or as needed. 2. If a resident is found to be at risk for elopement, the resident's care plan will include interventions for the prevention of elopement. The resident's picture will be located at stations or reception areas to alert staff of the possible risk of elopement. .5. When the resident is found, an in-depth physical assessment is completed by the charge nurse or designees with a specific focus on hypothermia, injuries etc., and treated as ordered by physician. The physician is notified along with the family and police, as needed. An incident report is completed. Documentation in nurse's notes is made. 6. Care plan interventions are documented and/or revised. 7. An immediate intervention is implemented to prevent further elopement. This may include 15-30 minute checks for at least eight hours or more, placement to secured unit, or use of a wander-guard. .10. The Director of Nursing completes an investigation of the elopement, including possible causes, the timeline, witness statements, immediate interventions, any permanent interventions, or any prevention measures . Facility Policy entitled 'Elopement Monitoring of Door Alarms, dated June 2014, states, in part: A specific system has been developed to notify staff that an external door has been opened in an area accessible to residents. Door alarms are tested each shift as least (sic) once a month. The results of the tests are then recorded. Testing of the systems includes not only that the alarms function, but also that staff respond appropriately to the alarms . Facility Policy entitled ' Resident Smoking Policy,' revised on 5/14/20, states, in part: It is the policy of this community to meet the needs and provide a safe environment for our residents to smoke. The facility will have a designated smoking area with designated supervised smoking times. Smoking will be prohibited in any other area and not allowed in any area inside of the facility. If it becomes necessary to restrict individual residents smoking privileges because of safety and/or a medical reason, such information will be noted in the resident's care plan. The smoking policy will be reviewed with resident and/or responsible party upon admission and as needed on an individual basis. Procedure: Smoking Environment, 1. The facility will provide an appropriate safe smoking area. This will be located outside the facility. 2. The facility will provide approved cigarette receptacles for residents to use. Ashtrays will only be emptied into a receptacle provided for such use. The facility will provide smoking blankets, fire extinguishers, and no oxygen signs in smoking area. 3. All smoking privileges shall be

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

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) suspended during a disaster, emergency situation, severe weather or a drill. 4. (Facility name) reserves the right to suspend or terminate smoking privileges at any time. .Designated smoking times. 1. Residents will have designated supervised smoking times, before and after meals, and prior to bedtime with the following times: 0700am (7:00 AM), 0900am (9:00 AM), 11:00 am, 1:00 pm, and 4:00 pm, unless otherwise designated by (Facility name) leadership. 2. Each smoking time will last no longer than 15 minutes, unless otherwise designated by (facility name) leadership. Assessment of Resident: .3. All residents that smoke will be assessed by the Life Enrichment Department, Nursing Personnel, or designees on admission, readmission, when there is a change in condition, quarterly and annually. This will determine if the resident can participate in supervised smoking. 4. There is to be no smoking in the facility at any time. .Smoking Equipment: .2. The facility has the right to conduct periodic checks in the resident's room if there are any safety concerns. .3. Smoking Material will be kept in the LTC (long term care) back nurses' station and the Aspen/Birch nurses' station for all residents. .Non-compliance corrective action. 1. If a resident is non-compliant with the smoking policy or exhibits ongoing unsafe smoking practices, they will be re-educated on the policy, reassessed on their ability to smoke independently and any of the following occur: a. Loss of ability to smoke while residing at the facility. b. be involuntary discharged from facility. 2. The actions taken will be documented in the medical records and the care plan will be updated . Example 1: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 is protectively placed and has a Guardian. Guardianship papers effective on August, 19, 2013 indicate that (R1) lacks evaluative capacity in full. Guardian of the person to exercise full power. R1's Annual MDS (Minimum Data Set) dated 3/13/20 indicates R1 has a BIMS (Brief Interview of Mental Status) of an 8 out of 15, which indicates he is moderately cognitively impaired. Section B indicates that R1 has clear speech, is able to make himself understood and can understand others. Section G indicates that R1 ambulates independently and is able to transfer independently with setup. R1's CNA (Certified Nursing Assistant) Care sheet received on 5/21/20 states, in part: Smoker; cigarettes locked in med cart (medication cart), nurse to dispense no more then 5 per day . provide walks outside as needed with supervision. Wanderguard 5/1/20. R1's Smoking Care Plan states in part: Focus: Resident is a smoker. Goal: will continue to be independent with smoking . Interventions: All smoking materials will remain locked in nurse med. cart. Date initiated: 04/16/2020. Facility will maintain safe place for smoking. Date initiated 03/07/2019. Resident receives 5 cigarettes per day that nursing distributes. Remind/encourage to keep within daily allotment. Date initiated: 03/12/2019 . Resident will be re-assessed for change in condition through 24 hours report and nurse observation. Date initiated 03/07/2019. Smoking assessment will be done at least quarterly and as needed. Date initiated 03/07/2019. Staff will manage smoking materials. Items to be given to resident when he/she wishes to smoke then collected upon re-entering the building. Date initiated: 03/07/2019. Will be assessed for changes in condition .Will be informed of smoking policy and will be assessed for compliance. Date initiated 03/07/2019. R1's Wanderguard Care Plan, states, in part: Focus: Problematic manner in which resident acts characterized by ineffective coping; wandering related to: Purposeful walks to w/o (sic) alerting staff. Date initiated: 05/12/2020. Goal: Resident will wander only within specified boundaries . Interventions: Allow Resident to wander on unit . Check daily to ensure resident has a wanderer's bracelet on .Document resident's whereabouts hourly on wanderer's checklist. Date initiated: 05/12/2020. Of note, the Wanderguard Care plan was not implemented timely, as it was not developed until 5/12/20 which is 11 days after R1's wanderguard was placed on 5/1/20. On 1/14/20 at 6:59 PM, R1's Nurses Note, states, in part: At approx. (approximately) 1840 (6:40 PM), community member came into building to report a resident was walking down the center of the frontage road towards Milwaukee St. (street). Upon locating resident at corner of street, writer interviewed (R1) I'm going for a walk. He was facing direction of convenience store. Writer helped (R1) negotiate traffic to cross the street and waited outside of convenience store while (R1) purchased a soda. (R1) was reminded to tell nursing staff if he was going for a walk. He shared with writer during the walk back that he bought a diet mountain dew. Writer educated (R1) that we had that soda in the machine. (R1) replied, I just wanted some exercise. (R1) chose to enter the building through the smoking area. (Note: To get to the convenience store/gas station, one would have to cross Milwaukee Street, which is a heavily-trafficked four lane road. There is not a cross walk where the frontage road intersects Milwaukee Street.) On 1/14/20, R1's Elopement Risk Full Screen tool indicates R1 does not have a history of wandering, elopement or getting lost. R1 is indicated as not being at risk for elopement. (R1) is aware of where he lives and has relationships with staff/peers, but he exhibits impulsive behaviors. He chose to go for a walk. Staff attended due to uneven surfaces present and traffic safety. Of note the facility was unaware R1 left the building until they were alerted by a community member that a resident was walking down the street, only then did a staff member intervene and walk with R1 to the convenience store. There is no indication that R1's Guardian was updated on R1 leaving the facility at this time. On 1/14/20 at 9:16 PM, R1's Nurses Note states, in part: Res. (Resident) continues on 15 min (minute) checks and educated on not to leave building without sign out/letting staff know for resident's own safety . On 1/15/20 at 4:02 AM, R1's Nurses Note states, in part: Patient continues to be on 15 minute checks . No further indication or mention of R1 being on 15 minutes checks after 1/15/20 and no evidence of a Care Plan being initiated for elopement at this time. On 3/12/20 at 10:47 AM, R1's Social Services Note states, in part: Voicemail left with resident's guardian rt (related to) resident walking to (gas station name) again this AM. Staff's desire to approach resident for consent to wear a wanderguard, and staff's desire to implement regular checks on resident if wanderguard not in place. Awaiting return call. There is no incident report or documentation regarding R1 going to the gas station on 3/12/20, in R1's medical record other than the Social Services Note indicated above. On 3/12/20 at 2:08 PM, R1's Social Services Note, states, in part: Spoke with Residents guardian regarding request for resident to wear wanderguard rt recent trips to (gas station name). Guardian in agreement with wanderguard and check ins, as well as planning for more supervision if refusing wanderguard . Of note, there is no documentation in R1's chart indicating whether or not R1 refused to have a wanderguard placed or that increased supervision was utilized. There is no evidence that an at risk for wandering/elopement or a wanderguard Care Plan was developed or implemented at this time. On 3/16/20 R1's Smoking Safety Full Screen Tool indicates R1 is able to use ashtray to self-extinguish cigarette. R1 can use lighter or matches safely. R1 is indicated as having a history of smoking-related incidents of burned clothing. Interventions indicated as 1. Independent and 7. Facility storage of tobacco products and fire materials. On 3/19/20 at 2:40 PM, R1's Social Services Note, states, in part: Phone conference held with .nurse case manager, resident's guardian . Resident's compulsive behaviors rt (related to) sugary foods/drinks has increased again. Blood sugars continue to spike and drop. .Resident's walks to gas station are most dangerous at this time. Currently managed as COVID-19 precautions require locked doors and supervised smoking. Guardian and staff concerned that in any unlocked unit resident may choose to leave facility for a walk or a trip to a nearby store. .Goal is to have a plan for limiting unsupervised trips out of the building before the end of Covid-19 precautions. Of note, R1's walks to the gas station are indicated as most dangerous at this time, yet there is no documentation of a plan for limiting unsupervised trips out of the building indicated in R1's care plan or R1's medical record. On 3/19/20 at 3:36 PM, R1's Nurses Note, states, in part: writer was notified that this resident was outside smoking around 2:30 PM, outside of the designated supervised smoking time. Resident was educated on 3/18/2020 by this writer that the smoking policy had changed, policy provided to resident. Writer found resident outside smoking a cigarillo and reminded resident of the policy. Resident proceeded to curse at writer and put out the cigarillo. Writer reminded resident of the next smoking time and where to find the smoking times were posted. Resident continued to curse at writer but then went back inside. Unit nurse was notified of the above. On 3/20/20, R1's Elopement Risk Quarterly Screen Tool indicates Resident is not at risk for elopement he has left the facility with purpose to go to the gas station and returns. However this is unsafe therefore resident is currently on 15 minute checks. (Note: Facility policy does not use the criterion of purposeful when describing what is elopement. As noted earlier, facility policy states: Elopement, for purposes of this policy and procedure, is defined as a situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety needs, and therefore at risk for injury outside the confines of the facility, has left the facility without the knowledge of staff.) On 4/13/20 at 12:04 PM, R1's Nurses Note, states, in part: Writer witnessed resident outside smoking during non-smoking times. Writer educated resident regarding smoking times. Resident threw cigarette out and states I hate you and followed writer back into the building. Will continue to monitor. Of note, there is no indication in R1's chart how R1 obtained smoking material to be outside during non-designated smoking times, or whether staff collected R1's smoking material upon reentering the building. On 4/16/20, R1's Smoking Safety Full Screen Tool, indicates R1 has a history of smoking-related incidents, indicated as other which states smoking after scheduled times. Interventions indicated as independent and all smoking materials are kept on nurses cart and a cigarette and lighter are given at allotted time. No assistant devices are needed. On 4/20/20 at 11:29 AM, R1's Nurses Note, states, in part: Pt (patient) observed outside at approx. 1110 (11:10 AM) picking up a cigarette butt from the cement and smoking. Writer

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) observed this from inside window. Pt. came inside after a few minutes and denied smoking stated I just went outside. Writer educated pt. on smoking policy and risk of losing privileges. Will cont (continue) to monitor. Of note, there is no indication in R1's chart how R1 obtained a lighter in order to be smoking on his own outside designated smoking times, or whether staff collected R1's smoking material upon re-entering the building. On 4/21/20 at 1:34 PM, R1's Nurses Note states, in part: Pt. went outside and was observed through nursing station smoking pt was not with staff. Nor did he inform staff of going out. Resident became combative, agitated w (with) writer. Was upset that I saw him and was concerned about when he would get his next smoke. Writer informed resident of next scheduled smoking time, 1245 (12:45 PM) and that it was only 1120 (11:20 AM). Pt. re-educated on smoking policy. Will cont. to monitor behaviors. Of note, there is no indication in R1's chart how R1 obtained smoking material to be outside during non-designated smoking times, or whether staff collected R1's smoking material upon re-entering the building. On 4/22/20 R1's Elopement Risk Full Screen Tool indicates R1 is independently mobile and is not at risk. Observation and evaluation states Resident chooses to leave the building at times to go on a walk, each exit is purposeful/intentional. Not at risk for wandering. On 4/22/20 at 2:30 PM, R1's Nurses Note, states, in part: Resident left building to go For a walk without notifying staff. Staff observed resident outside of smoking entrance gate, resident was given education by DON (Director of Nursing) and Social Services about asking for staff to accompany him on his walks. SW (Social Worker) to call guardian. Completed an elopement assessment, resident is not at risk for elopement. Each exit of the building is purposeful. Will update care plan and care delivery guide to provide walks outside as needed weather permitting, initiated 15 min checks at this time. Of note, there is no indication in R1's chart how R1 obtained smoking material to be outside during non-designated smoking times, or whether staff collected R1's smoking material upon re-entering the building. This is approximately the 7th time that has been documented that R1 has went outside without informing staff. 15 minute check sheets completed for R1 on 4/22/20, 4/23/20 and 4/24/20. On 4/30/20 at 11:33 AM, R1's Nurses Note, states, in part: Resident observed to be outdoors smoking without a staff member at approximately 1115 (11:15 AM). Writer observed this from inside therapy dining room window as resident was sitting in front of this door so as not to be seen. Writer educated him on smoking policy, scheduled times and possible risk of losing privileges Resident put out his cigarette which appeared to be a shorter one possibly saved from a previous smoking time. Resident then came inside saying I hate this place several times. Of note, there is no indication in R1's chart on whether staff collected R1's smoking material upon re-entering the building. On 5/1/20 at 3:15 PM, R1's Nurses Note, states, in part: Resident doesn't have cigarettes left. He says I have cigarettes in my room stashed from previous times. I am good for today. The activity assistant refilled his cig. (Cigarette) box in the end of the shift. Of note, there is no indication that R1's smoking materials had been removed to be placed and stored in the Nurses cart after staff were made aware that R1 possessed smoking materials in his room. On 5/1/20 at 4:24 PM, R1's Nurses Note, states, in part: Call placed to (Guardian's name), guardian to report resident independent purposeful walk to (gas station name). Resident is free from injuries. DON and Social Worker provided education to resident about safety and inability to walk freely in the community at this time. Resident became agitated but stated he understands. Immediate interventions: Place on 15 min checks and apply wanderguard to left ankle. Resident states he will keep this on. Education provided to PM facility staff and unit nurse about the above. DON and Social Worker updated (Guardian's name) and voiced concerns about resident unsafe choices that put him and the facility at risk. DON and SW also discussed residents noncompliance with smoking times and inability to follow the policy and procedures related to smoking. (Guardian's name) stated understanding. DON and SW updated (Guardians name) about the non-diabetic items found in residents drawer. Resident is safe at this time and stated understanding of the above . On 5/1//20 at 10:45 PM, R1's Nurses Note, states, in part: Resident was found outside, wandering across the street in (gas station name). On 15 minute checks, isolation and wanderguard place on L ankle (sic). Guardian notified by DON . On 5/2/20 at 1:45 AM, R1's Nurses Note, states, in part: .Resident during the night did come out of room to go smoke without any PPE (personal protective equipment) items on. But as soon as the wanderguard alarm went off resident went back to room & (and) did not go out to smoke. Resident again reminded that he is on isolation & con (sic) not come out of room without PPE on or go out to smoke until designated times . On 5/3/20 at 1:55 PM, R1's Nurses Note, states in part: Resident was found in his room w (with) a partial pack of cigarettes. Pt initially denied having them but then said he has been saving them. 4 (four) full cigarettes and several short cigarettes. Pt did give them to writer, and apologized. Writer will f/u (follow up) w RNCM (Registered Nurse Case Manager) tomorrow. Pt. stated awareness of smoking policy and risks of noncompliance. Of note, there is no indication in R1's chart how R1 was able to save cigarettes, if staff are to be collecting and handing out R1's smoking material during designated smoking times. There is no indication of follow up in R1's chart from the RNCM regarding this incident. On 5/4/20 at 6:47 AM, R1's Nurses Note, states in part: Resident was found outside smoking today before 6AM - outside of the scheduled smoking times. Resident came inside when informed that he was not to be out smoking. Resident is aware of the smoking times and was educated again that he was not to be out smoking outside of those times for the safety of all residents during this pandemic. Of note, there is no indication in R1's chart how R1 obtained smoking material to be outside during non-designated smoking times, or whether staff collected R1's smoking material upon re-entering the building. There is no indication of how R1 was able to get outside without staff supervision due to having a wanderguard on his left ankle which should have set off the door alarm. On 5/4/20 at 9:38 AM, R1's Nurses Note, states in part: Pt seen in room holding pack of cigarettes, second time in 2 days. Pt immediately stated he needed to use bathroom and was then observed flushing the toilet. Pt then handed writer a crumpled up pack of (brand of cigarettes) with no cigarettes inside. Pt states he didn't flush them, he had gotten them from saving them and that nobody gave them to him. Will cont to monitor for behaviors as pt is having difficulty w (with) new times and policy. Of note, R1 continues to have smoking material on him within the facility, when staff are to be supervising his smoking times, maintaining and holding onto his smoking materials. On 5/6/20 at 2:58 PM, R1's Nurses Note, states in part: was observed smoking outside indep (independent) at 1120 (11:20 AM). Pt denied this but eventually admitted to smoking a butt of a shorted cigarette. Pt reluctant to any education and further stated I hate it here. Will cont. to monitor. Of note, R1 continues to have a wanderguard on at this time, yet he was able to be get outside without staff's knowledge. R1's wanderguard should have set off the alarm if it was functioning properly to alert staff that R1 was outside. There is no indication in R1's chart if the alarm was sounding or how R1 was able to get outside without supervision. 15 minute check sheets completed for R1 on 5/10/20 and 5/11/20. On 5/13/20 at 12:46 PM, R1's Nurses Note, states in part: CNA reported resident smoking in his room. Resident denied smoking cigarettes. Reported to DON and Administrator. On 5/14/20 at 6:13 PM, R1's Nurses note, states in part: CNA reported cigarette smell in resident's room. Resident denied smoking cigarettes. Reported to Social Worker. On 5/18/20 at 3:09 PM, R1's Nurses note, states in part: .CNA reported she went into residents room and smelled smoke, writer asked resident if he was smoking in his room and he said yes in my bathroom. Writer asked why and resident stated I don't know why reported to Administrator and (Nurse Practitioner). Of note, there is no indication in R1's record of how R1 had smoking materials in his room, if staff are to be maintaining and distributing his smoking materials. There is no indication of a new smoking assessment being completed or new interventions being put in place to ensure that R1 does not have smoking materials on him while in the facility. R1's May 2020 TAR (Treatment Administration Record) states in part: 5/1/20, 15 min checks and check L (left) ankle every shift for wanderguard. 5/21/20 check wanderguard placement daily Q (every) shift. 5/21/20 Check wanderguard functioning on NOC (night) shift. Of note,there is no evidence of documentation between 5/1 and 5/21 that R1's wanderguard was checked for functioning. On 5/21/20 at 9:30 AM, Surveyor observed the smoking area off of the Birch hallway. CNA J was outside at this time with three different residents, none of which were R1. No cigarette butts observed on the ground at this time and ash tray receptacles were visible. On 5/21/20 at 10:50 AM, Surveyor was informed by NHA A that there are no recent elopements and that R1 went out for a walk and came back. NHA A indicated that is not considered an elopement due to being purposeful and he returned. On 5/21/20 at 12:00 PM, Surveyor interviewed RN K (Registered Nurse) regarding R1. RN K indicated that she has worked down Cedar Hall a few times and a CNA reported smelling smoke in a resident room. RN K indicated she went down and did not find any cigarettes in the room. RN K indicated she does not remember who the CNA was. On 5/21/20 at 12:05 PM, Surveyor interviewed LPN I regarding R1. LPN I indicated that R1 gets 5 (five) cigarettes a day and a CNA walks him out. LPN I indicated there is not a lighter in his box or in the cart. Surveyor observed LPN I check R1's left ankle at this time and observed R1's wanderguard to be in place. On 5/21/20 at 12:10 PM, Surveyor interviewed LPN E regarding R1 and smoking. LPN E indicated if a resident is in danger of walking away, shown behavior or talked about wandering then the resident has a wanderguard. LPN E indicated the wanderguard has to be on the person and not on the wheelchair or walker. LPN E indicated the WG (wanderguard) will set off the door and staff respond to the alarm. LPN E indicated they have a wander booklet and that R1 just transferred from Birch. LPN E indicated that a wanderguard was placed on R1 because he walks to the gas station to buy cigarettes and lighters. LPN E

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELMONT NURSING AND REHAB CTR	110 BELMONT RD MADISON, WI 53714

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) indicated that R1 has not gone to the gas station since his WG was placed and on lock down due to COVID 19. LPN E indicated that none of the residents are allowed to go across the street especially Milwaukee Street. LPN E indicated that R1 is not in the wander book on Cedar and she believes Birch has their own. LPN E indicated that R1 has had a WG for about 2 to 3 weeks. LPN E indicated protectively placed residents or residents with a Guardian are not allowed to leave unless permission to do so and referred Surveyor to Social Worker (SW). LPN E indicated whoever was available, goes out with residents to smoke due to knowing times. LPN E indicated the smoking area is by the NHA A's office. LPN E indicated that smoking materials are kept in the medication carts and staff dispense them as residents come up to you and staff hand them (cigarettes) out to them. LPN E indicated that R1 will get cigarettes from nursing and she does not think he has a lighter. LPN E indicated she thinks the person who goes out will light everyone's cigarettes. On 5/21/20 at 12:20 PM, Surveyor interviewed NHA A regarding R1. NHA A indicated that she thought they discontinued R1's wanderguard and that is why R1 is not in the wanderguard book. NHA A indicated that R1 was not in the Birch hall book for wanderers. On 5/21/20 at 1:03 PM, Surveyor interviewed PTD G (Physical Therapy Director) regarding R1. PTD G indicated that R1 is pretty safe and low blood sugars seem to be his only barrier. PTD G indicated R1's balance is normal for him, but from a cognitive perspective he is not aware of his safety. PTD G indicated R1 was deemed safe to smoke, but cognitively he shouldn't be leaving due to mentation and due to his fragile diabetes. PTD G indicated she is unware if a full cognitive assessment was completed for R1. On 5/21/20 at 1:40 PM Surveyor interviewed NHA A regarding R1. NHA A indicated she spoke with the DON (Director of Nursing) regarding R1, prior to R1 wandering and that R1 was deemed safe. NHA A indicated that R1 went outside and would come back. NHA A indicated that R1's Guardian does not want him leaving the building without staff. NHA A indicated that R1's wanderguard has been charted on and functioning since 5/1/20 when it was placed on R1. Surveyor asked NHA A if the wanderguard alarm sounded when R1 left the building. NHA A stated based on what is charted on 5/4/20 progress note, you're not able to tell if the wanderguard alarm was sounding. NHA A indicated that R1 is no longer on 15 minute checks as they were only done initially due to staff being worried he would take the wanderguard off. NHA A indicated that the nurse keeps his smoking material as R1's guardian only allows him to a certain amount of cigarettes per day. NHA A indicated that the nurses give out R1's cigarettes and that the nurse should be checking in with R1 and taking smoking materials back at the end of the smoke breaks. NHA A indicated she is not sure how R1 had smoking materials in his room. NHA A believes he may have been saving them or picking the items up. Surveyor asked NHA A regarding why the wanderguard palcement did not occur prior to 5/1/20. NHA A indicated this was the first time R1's guardian was angry regarding R1 going outside and does not want him to leave. NHA A A indicated that R1 can smoke independently and that an independent smoker means they're able to hold a cigarette, ash a cigarette and light their own cigarette and that staff just monitor their materials. NHA A indicated that laundry staff check for holes in clothing as well as regular staff on the units. On 5/21/20 at 2:09 PM, Surveyor interviewed SW C regarding R1. SW C indicated that R1's guardian has a concern with him leaving because he's a brittle diabetic and has a habit of getting items that raise his blood sugars. SW C indicated there have been a few incidents where he has went to the gas station unannounced and concerns with smoking materials. SW C indicated that R1 goes out to smoke when he's not supposed to and that R1 picks up cigarette butts off the ground and is sharing butts with others. SW C indicated a couple situations have occurred regarding going to the gas station. SW C indicated that they received a call from staff, who were leaving the building. SW C indicated that when they reached R1 he was already turned around and headed on his way back to the building. SW C indicated that R1 stated I'm just walking. SW C indicated that R1 was educated to talk to staff before leaving the building and before going out. SW C indicated that R1 is protectively placed, as this is a facility that is deemed safe for placement. S
F 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility did not ensure Certified Nursing Assistant (CNA) staff completed 12 hours of annual in-servicing or received a performance review at least every 12 months for 5 of 5 staff members selected for review. CNA H was hired on 11/25/13, did not have an evaluation in the past 12 months. CNA L was hired on 5/29/12, did not have an evaluation in the past 12 months. CNA M was hired on 3/27/18, CNA M did not complete 12 hours of in-service training CNA N was hired on 4/12/19, CNA N did not complete 12 hours of in-service training CNA O was hired on 7/31/18, CNA O did not complete 12 hours of in-service training and did not have an evaluation in the past 12 months. This is evidenced by: Facility Policy, entitled 'Performance Review Policy, dated June 2018, states, in part: .Management and direct supervisors are responsible for providing ongoing, performance feedback to each employee. In addition, an employee's direct supervisor will formally discuss and document employee performance on a regular annual basis. .9. Human Resources will maintain performance reviews according to record retention guidelines . Facility Policy, entitled 'In-Service Programs (General),' Revision date of June 2017, states, in part: An ongoing, planned education program is conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Training will be performed via computer (name of system) or in-person. Each employee is responsible for attending the minimum required hours and the required programs. The community Human Resources department will assure that all training is scheduled, performed and properly documented and recorded in each employee file. .Assure that all training records are complete and tracked back to the employee file on a monthly basis. Assure that all scheduled training accurately reflects the needs of the staff and resident population, and make changes as identified through coaching sessions, disciplinary action, culture of community, incidents/accidents, grievances, resident disease/care plans, state and federal requirement changes, and changes internally and externally . On 6/2/20 at 2:30PM to 2:45PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding CNA annual reviews and 12 hours of required training. NHA A indicated that staff are to have 12 hours of training and that the facility goes off of employees hire dates. NHA A indicated that reviews are to be done annually. Example 1: CNA H (Certified Nursing Assistant) was hired on 11/25/13, did not have an evaluation in the past 12 months. CNA H's last review is dated 12/6/18, CNA H was due for an evaluation on or around 11/25/2019. On 6/2/20 at 2:30 PM to 2:45 PM, Surveyor interviewed NHA A regarding CNA H. NHA A indicated that CNA H should have a more recent evaluation done. Example 2: CNA L (Certified Nursing Assistant) was hired on 5/29/12, did not have an evaluation in the past 12 months. CNA L's last review is dated 6/17/16, CNA L was due for an evaluation on or around 5/29/19. On 6/2/20 at 2:30 PM to 2:45 PM, Surveyor interviewed NHA A. NHA A indicated that she was only able to find an evaluation for CNA L from 6/17/16. NHA A indicated that an updated review needs to be done. Example 3: CNA M (Certified Nursing Assistant) was hired on 3/27/18, CNA M did not complete 12 hours of in-service training between 3/27/19 and 3/27/20. On 6/2/20 at 2:30 PM to 2:45 PM, Surveyor interviewed NHA A regarding CNA M's training hours. NHA A indicated that CNA M only has 9.5 hours total of education and that CNA M should have 12 hours of training. Example 4: CNA N (Certified Nursing Assistant) was hired on 4/12/19, CNA N did not complete 12 hours of in-service training between 4/12/19 to 4/12/20. On 6/2/20 at 2:30 PM to 2:45 PM, Surveyor interviewed NHA A regarding CNA N's training hours. NHA A indicated that CNA N only has 7.5 hours of training and should have 12 hours of training. Example 5: CNA O (Certified Nursing Assistant) was hired on 7/31/18, CNA O did not complete 12 hours of in-service training for 2019. CNA O was hired on 7/31/18 and does not have an evaluation and was due for a performance review on or around 7/31/19. On 6/2/20 at 2:30 PM to 2:45 PM, Surveyor interviewed NHA A regarding CNA O's training hours and evaluation. NHA A indicated that CNA O only had 11 out of 12 required training hours for 2019. NHA A indicated that CNA O should have a recent performance evaluation and that NHA A was unable to locate a recent evaluation for CNA O.