



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Eklar Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

February 3, 2015

Judy L. Moore, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Ms. Moore:

On **January 16, 2015**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Safe Haven Care Center of Pocatello by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

Judy L. Moore, Administrator
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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 17, 2015**. Failure to submit an acceptable PoC by **February 17, 2015**, may result in the imposition of civil monetary penalties by **March 9, 2015**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **February 20, 2015** (**Opportunity to Correct**). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 20, 2015**. A change in the seriousness of the deficiencies on **February 20, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February**

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20, 2015 includes the following:

Denial of payment for new admissions effective **April 16, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 16, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 16, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

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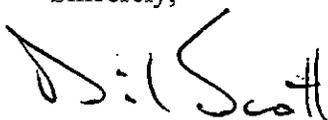
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 17, 2015**. If your request for informal dispute resolution is received after **February 17, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID J. SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal Recertification and complaint survey of your facility. The survey team entered the facility on January 12, 2015 and exited the building on January 16, 2015.</p> <p>The surveyors conducting the survey were:</p> <p>Amy Barkley, RN, BSN, Team Coordinator Linda Hukill Neil, RN Brad Perry, LSW</p> <p>Survey definitions were:</p> <p>ADON/ADNS = Assistant Director of Nursing AIT = Administrator in Training CCC = Clinical Care Coordinator CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON/DNS = Director of Nursing Erythema = Redness GDR's = Gradual Dose Reduction GERD = Gastroesophageal Reflux Disease hrs = Hours IDT = Interdisciplinary Team HS = Hours of Sleep LN = Licensed Nurse LPM = Liters per minute MAR = Medication Administration Record mg = milligram mcg = micrograms NC = Nasal Cannula PRN = as needed pt's = patient's RR = Random Resident s/s = signs and symptoms TAR = Treatment Administration Record UTI = Urinary Tract Infection</p>	F 000	<p>Preparation and for execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary.</p>	02/20/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy R. Moore</i>	TITLE Administrator	(X6) DATE 03/25/15
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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 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>F156</p> <p>Current Residents: Resident #26 has been discharged. Resident# 27 and 28 are now covered under Medicaid.</p> <p>Potential New Residents: All new residents receiving therapy services will be notified of changes in services through the new process. New Process: 1. Safe Haven is now using a revised ABN form that allows for an issue date and a notice of when services are ending date. We have adopted the CMS-10055 form at the recommendation of the survey team. 2. Safe Haven corporate AR manager responsible for sending and receiving the ABN's attends facility stand up meeting twice a week to discuss changes to services and any subsequent required notification of changes to patient or patient authorized representative. 3. Safe Haven corporate AR manager will prepare the ABN notice, including notice date, specific services ending and for what reason, and the date services will end. 4. Safe Haven corporate AR manager will hand deliver the ABN notice to the patient at the facility for receipt and signature for any patient who is their own legal person (no guardian) and is capable of understanding the content of the ABN notice.</p>	02/20/2015	

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F 156	<p>Continued From page 2 funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156	<p>Continued from page 2</p> <p>5. For any patient who is NOT their own legal person (has a guardian or authorized representative) or is NOT capable of understanding the content of the ABN notice, the Safe Haven corporate AR manager will:</p> <ul style="list-style-type: none"> a. Attempt phone contact to let the authorized representative know the ABN notice is on its way and explain what it means and that a signed copy is required to be returned. b. Upon request from the authorized representative, fax or email a copy of the ABN notice for their review. c. Print a hard copy of the ABN notice and send it via USPS certified mail to the authorized representative with return receipt option. The ABN notice will be mailed with a prepaid, self-addressed envelope to ensure expediency and ease of returning the notice. <p>Monitoring: The following process of monitoring will be followed for all ABNs sent:</p> <ol style="list-style-type: none"> 1. Safe Haven corporate AR manager will keep a copy of the sent ABN notice in a tickler file for follow up until the signed notice is received back. 2. Safe Haven corporate AR manager will attempt phone contact with the authorized representative within 5 days after receipt of the USPS certified letter return receipt if the signed ABN notice is not yet received. Ongoing phone contact will be attempted at a frequency of once a week until the signed ABN notice is received. The Safe Haven corporate AR manager will note all contact attempts including date, time, who was contacted, and the content of the message left at the bottom of the ABN notice copy in the tickler file for proof of timely notification until the signed ABN notice is received. 	02/20/2015	

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were provided advance notice of their right to appeal the facility's decision that Medicare would no longer pay for skilled care. This deficient practice was true for 3 of 3 (#s 26, 27, and 28) random residents reviewed for notice of Medicare non-coverage. This failure created the potential for psychological harm when the residents were not provided notice of their right to appeal the decision. Findings included: Resident #s 26, 27, and 28 had each received completed Advance Beneficiary Notice of Noncoverage (ABN) from the facility. Resident #26's ABN for Speech Therapy and Resident #27's ABN for Occupational Therapy documented their Medicare coverage could change, the reason Medicare may not pay, and the estimated cost for the therapy. Neither resident's ABN documented the service coverage end date or the date of notification. The residents had not selected 1 of the 3 options indicating if they wanted to: 1. Have services continued and have Medicare billed; if Medicare did not pay the resident would be responsible for payment or could file an appeal to Medicare; 2. Services continued and the resident would be responsible for payment; or 3. Services discontinued and the resident would not be responsible for payment; the resident could not appeal to Medicare for payment.	F 156	Continued from page 3 3. Once the signed ABN notice is received, the Safe Haven corporate AR manager will: a. Forward a copy of the signed ABN notice to the facility medical records department for filing in the patient chart b. Take the original copy of the signed ABN, the USPS certified letter return receipt, and the copy of the ABN notice with contact effort details from the tickler file, staple them together and place the complete ABN notice packet in the patient financial	02/20/2015	

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F 156	Continued From page 4 Resident #s 26 and 27's ABN did not have a signature and a date acknowledging that they had received and understood the notice. Resident #28's ABN for Physical Therapy documentation was completed, signed and dated by her authorized representative, but it did not contain a date of when the services were considered "non-covered" by Medicare. The resident's ABN did not document if the resident or the representative were given advance notice for the change in service coverage. On 1/15/15 at 5:01 PM, when the Accounts Receivable Manager (ARM) was asked by the surveyor how the facility had ensured the residents had received advance notice of Medicare non-coverage services, the ARM stated she did not have a specific date of non-coverage listed, but the department that provided the covered skilled care would alert her 72 hours in advance and give her the names of the residents with Medicare non-coverage changes. The ARM said she made contact with the cognitive residents in person or with the resident's representative by phone. She said she would tell the representatives she would mail a letter with instructions along with an ABN that needed to be completed and mailed back to the facility. The ARM stated, "I don't think they know the importance of it." On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. No other information or documentation was received from the facility.	F 156			
F 164	483.10(e), 483.75(l)(4) PERSONAL	F 164			02/20/2015

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F 164 SS=D	<p>Continued From page 5 PRIVACY/CONFIDENTIALITY OF RECORDS.</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to protect a resident's personal medical information. This was true for 1 of 13 sampled residents (#8). This failed practice created the potential to negatively affect the resident's psychosocial well-being.</p>	F 164	<p>F164</p> <p>Current Residents: Resident #8 continues to reside at the facility and will be weighed using the new process.</p> <p>Potential New Residents: Potential new residents will be provided personal privacy and confidentiality through the use of the new process.</p> <p>New Process: Residents will be weighed by a staff member in the therapy room or in their individual room only. The scale monitor will be covered at all times except when the staff member is reading the results of the weigh. At that time, the staff member will continue to take measures to ensure continued privacy by quickly reading the weight and then clearing the scale. The weight will be documented in a binder that will be kept at the nurses' station.</p> <p>Training: All staff were in-serviced by the ADNS and CDM on this new process for weighing residents.</p> <p>Monitoring: The Program Coordinator will audit the weight process on a weekly basis X4, then monthly X3.</p>	02/20/2015

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F 164	Continued From page 6 Findings included: On 1/15/15 at 9:55 AM, CNA #1 was observed next to a portable scale, diagonally across the hallway from the Cape Elizabeth nurses station. Resident #8 was in the hallway in her wheelchair near the scale. CNA #1 informed the resident he was going to weigh her and moved her onto the scale. The digital readout of the resident's weight was displayed on the scale and was visible to anyone who walked by. On 1/15/15 at 10:00 AM, CNA #1 was interviewed regarding the public weighing and visible weight readout on the scale where Resident #8 was just weighed. He said he normally weighed residents in the hallways and sometimes in their rooms. He also said he normally tried to cover up the readout with a piece of paper, but that he did not conceal the digital readout in the observed instance. On 1/15/15 at 7:15 PM, the DNS was interviewed regarding the privacy issue. When asked if the observation was an acceptable practice, she stated, "No it is not." On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were notified of the issue. No further information was provided by the facility.	F 164		02/20/2015	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		02/20/2015	

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F 226	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interviews, it was determined the facility failed to operationalize its abuse policies and procedures when it failed to obtain reference checks for 3 of 5 employees reviewed for reference check (Staff A, B, & C). This practice created the potential to place residents at risk for and subject to abuse, neglect, or misappropriation of property. Findings included:</p> <p>The facility abuse policy and procedures documented the following: "1. SCREENING: All new employees will be screened prior to employment...a. The Director of Nursing will make every effort to notify past and current employers...for each new employee."</p> <p>On 1/15/15 at 11:40 AM, five employee personnel files were reviewed for reference checks with the Human Resources Director (HRD). Staff A, B, and C were hired on 12/3/14, 11/24/14, and 11/17/14 respectively. Staff A and B's files did not document references were completed and staff C's reference checks were not dated as to when the reference checks were completed. The HRD said she was new to the job and would look to see if their corporate office had completed reference checks.</p> <p>On 1/15/15 at 2:55 PM, the HRD informed the surveyor the corporate office did not have any further information regarding the reference checks.</p>	F 226	<p>F226</p> <p>Current Residents: All residents had the potential of being affected.</p> <p>Potential Residents: Potential residents will be protected by the facility operationalizing its policies and procedures including the new process.</p> <p>New Process: The facility hired a new HR Director, the first HR Director the facility has employed at the building. She started on 12/10/2014. She implemented a process where she interviews an applicant, checks the references of the applicant and documents the reference check on the applicants form with date and time. This is kept in the applicants employment file.</p> <p>Training: The new HR Director trained the HR/staffing department on the new process and the auditing process to be completed.</p> <p>Monitoring: The Administrative Coordinator will monitor all new hire records X3 months to ensure references were completed and in a timely manner.</p>	
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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F 226	Continued From page 8	F 226		02/20/2015	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Resident Council Minutes, the resident group interview, and staff interview, it was determined the facility failed to ensure: *Floors were cleaned in resident #4's room and the bathroom in resident #1's room, which was shared by two other residents in room 38; *Bathroom toilets were properly cleaned and in good repair in resident #1's room, which was shared by two other residents in room 38, and in resident room 17; *Closets were free of exposed wood in resident #5's room and resident room 45; *Window blinds were not damaged in resident room 10; *The Seaside Dining Room was free of peeled paint; and *Offensive odors were not present outside of resident #4's room and in the Cape Elizabeth and Hatteras hallways. This had the potential to affect residents and decrease the quality of life of residents who resided in or frequented these areas. Findings</p>	F 253	<p>F253</p> <p>Current Residents: Resident #4 and #1 rooms were deep cleaned immediately at the time of survey and placed on a deep clean schedule by the supervisor of the housekeeping department. Resident #5 and Room #45 are now free of exposed wood on the closets. All patient rooms on Cape May have been freshly painted, as has the Seaside Dining, the Wharf Dining Room and other areas that are continued parts of the ongoing construction. The blinds were replaced in room #10. The motion odor dispensers were immediately at the time of survey restocked and housekeeping staff were reeducated by the supervisor.</p> <p>Potential Residents: The facility will provide housekeeping and maintenance services necessary to maintain sanitary, orderly, and a comfortable interior for all residents.</p> <p>New System: The Housekeeping Supervisor has established a deep clean schedule for all rooms to ensure a cleaner environment. All hallways and dining rooms have been put on a strip and wax schedule. Maintenance has a work order clip board at each nurses' station, the board is checked daily for repair needs.</p>	02/20/2015	

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F 253	<p>Continued From page 9 included:</p> <p>Resident Council Minutes dated 9/11/14, documented, "...toilets are still not being scrubbed properly." The Response section of the meeting minutes, dated 9/17/14, documented, "...The custodial staff will be trained to be more aware of the toilet cleaning."</p> <p>Resident Council Minutes dated 11/13/14, documented, "...inside of toilets are stained still." The Response section of the meeting minutes documented, "I will inservice staff and reeducated them on basics of housekeeping."</p> <p>On 1/14/15 at 2:00 PM, during the resident group interview, 4 of 16 residents stated the toilets were not clean and 2 of 16 residents stated resident room floors were not cleaned around the edges.</p> <p>1. On 1/12/15 at 1:05 PM and 4:12 PM, 1/13/15 at 7:55 AM and 1:45 PM, the bathroom floor in resident room 37/38 had a sticky substance on the floor in front of the toilet.</p> <p>On 1/13/15 between 2:25 PM and 2:32 PM, a housekeeping staff member was observed cleaning resident room 37 and the bathroom, which included mopping the bathroom floor.</p> <p>On 1/13/15 at 3:00 PM, the bathroom floor was observed to be slightly wet and was still sticky.</p> <p>On 1/14/15 at 9:25 AM, the Housekeeping Supervisor was shown the bathroom and asked about the sticky floor. He said, "It looks like BM [bowel movement], it's sticky." When informed about the above observations, he stated, "I'll fix it."</p>	F 253	<p>Training: The housekeeping supervisor has trained all his staff on cleaning schedules, deep cleaning routines, a 5 and 7 step cleaning process, and reeducated on the use of proper chemicals.</p> <p>Monitoring: Daily Environmental Rounds will be performed by administrative staff and/or housekeeping supervisory staff daily on an ongoing basis. The following will be monitored; lobbies, untis, dinning rooms, shower rooms, and therapy rooms. Each area will be monitored for cleanline, odors neatness, trash, repairs, and contraband.</p>	02/20/2015

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F 253	<p>Continued From page 10</p> <p>2. On 1/13/15 at 7:55 AM and 1/14/15 AM, the bathroom toilets in resident rooms 37/38 and 17 were observed. Room 37/38's toilet seat had two inches of missing enamel from the front inside area of the toilet seat, which exposed the toilet seat wood. Both toilets contained brown discolored streaks along the inside and bottom of the toilet bowls.</p> <p>On 1/14/15 during the environmental tour between 3:05 PM and 3:40 PM, the Maintenance Supervisor was interviewed regarding the toilet conditions. In room 17 he said the toilet contained, "Hard water build-up" and housekeeping was suppose to clean them with a chemical which breaks down the build up. In room 37/38, he said the bathroom "could use a complete new" toilet.</p> <p>3. On 1/12/15 from 1:00 PM to 1:12 PM, the closet doors in resident rooms 43 and 45 were observed with scrapes that exposed the wood.</p> <p>On 1/14/15 during the environmental tour between 3:05 PM and 3:40 PM, the Maintenance Supervisor was interviewed regarding the doors. He said the doors "needs [to be] repainted."</p> <p>4. On 1/13/15 at 8:15 AM, the window blinds in resident room 10 were observed with 10 bent slats on the right side of the blind.</p> <p>On 1/14/15 at 4:40 PM, the Administrator, ADNS, and Clinical Care Coordinator were informed of the issue.</p> <p>5. On 1/13/15 at 3:02 PM, the Seaside Dining Room was observed to have missing and peeled</p>	F 253		02/20/2015	

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F 253	<p>Continued From page 11</p> <p>paint, which exposed the drywall. The following areas of peeled or peeling paint were also observed:</p> <ul style="list-style-type: none"> *A two foot long and two inch wide section just above the baseboard and under the window; *A two foot long and three inch wide section next to a wall heater; *An eight inch long and three inch wide section to the left of a wall heater; and, *A three foot long and one to six inch wide section to the left of the sink. <p>On 1/14/15 during the environmental tour between 3:05 PM and 3:40 PM, the Maintenance Supervisor was interviewed regarding the paint issues. He said they were "wheelchair scrapes."</p> <p>6. On 1/15/15 at 4:40 PM, offensive odors were detected between resident rooms 18 and 20 in the Cape Elizabeth hallway and also near the Cape Hatteras nursing station.</p> <p>On 1/15/15 at 4:42 PM, the Housekeeping Supervisor was interviewed regarding the smells; he identified the smell as bowel movement and said, "I'll take care of it."</p> <p>7. On 1/13/15 from 8:00 AM to 4:30 PM and on 1/14/15 from 7:40 AM to 2:30 PM, the following was observed in Resident #4's room:</p> <ul style="list-style-type: none"> - Heel lift boots and heel lift pad were soiled with dried brown/yellow residue. - Six used alcohol wipes, a cap from a saline flush syringe, IV bag, tube feeding bottle; black stethoscope; used adhesive strip; blue cap from IV antibiotic; and a used glove were found on the floor and/or under the resident's bed. - The bed side table was covered with a white film 	F 253		02/20/2015	

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F 253	Continued From page 12 and had the resident's suction machine placed on it. - The floor on the right side of the resident's bed; the bed frame; and the air mattress overlay had multiple areas of a dried yellow/white flaky residue. - Used feeding tubing was wrapped around the resident's oxygen tubing and the right side rail, with the end of the tubing and the empty bottle in the garbage can. - An odor of stale, pungent urine and sweat were smelled outside Resident #4's room. On 1/14/15 at 2:30 PM the Training Manager confirmed the presence of the above findings and stated the condition of the room was unacceptable and not clean. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were notified about the above concerns and no further information was provided.	F 253		02/20/2015	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		02/20/2015	

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F 272	<p>Continued From page 13 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to care plan incontinence care and psychotropic drug use after an MDS CAA triggered for these issues. This was true for 1 of 13 (#1) sampled residents. This had the potential to harm the resident if the resident suffered urinary or psychosocial declines due to insufficient care. Findings include:</p> <p>Resident #1 was readmitted to the facility on 10/26/14 with multiple diagnoses including end stage renal disease.</p>	F 272	<p>F272</p> <p>Current Residents: Resident #1's Care Plan and MDS has been reviewed by the IDT and updated.</p> <p>Potential New Residents: All residents will be assessed initially upon admission, quarterly, and with significant change to receive an accurate comprehensive assessment performed by the IDT.</p> <p>New Process: The IDT meets twice weekly to discuss resident needs, all members attend the MDS and Care Plan are completed based on the agreed upon needs. A Care Plan conference is set up to discuss the drafted forms and if the resident and/or designated representative agree with the POC it is finalized and implemented. The IDT completes a sign in sheet which lists all the attending members and the date.</p> <p>Training: All IDT staff have been educated regarding the new process of POC by the DNS and ADNS.</p> <p>Monitoring: IDT will monitor annual and quarterly MDS/Plan of care to assure the PoC addresses issues identified in section V of the MDS, for accuracy weekly.</p>	02/20/2015

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F 272	<p>Continued From page 14</p> <p>The resident's annual MDS assessment, dated 7/24/14, documented the resident was continent of bladder and was cognitively intact with a BIMS of 15.</p> <p>Section V CAA Summary of the annual MDS assessment, dated 7/24/14, contained an 'X' mark in the Urinary Incontinence and Indwelling Catheter and Psychotropic Drug Use sections titled Care Planning Decision, which indicated the area would be care planned.</p> <p>Note: The resident's care plan did not address Urinary or Psychotropic Drug care.</p> <p>On 1/15/15 at 1:10 PM, the MDS Coordinator was interviewed regarding the CAA issue. She acknowledged the missing care areas were not in the resident's chart and should have been included to address these issues.</p> <p>On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the CAA issue. No further information was provided by the facility.</p>	F 272		02/20/2015
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>	F 279		02/20/2015

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F 279	<p>Continued From page 15</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure a individualized care plan was developed to treat a resident admitted with urinary retention, or address needs, treatments, and parameters for physician notification. This was true for 1 of 10 (#8) sampled residents. This had the potential for more than minimal harm if the resident developed a urinary tract infection, discomfort, acute renal failure, and/or urosepsis related to retained urine. Findings included:</p> <p>Resident #8 was admitted to the facility on 2/5/14 with multiple diagnoses including diabetes, chronic kidney disease, urinary tract infection, lumbosacral stenosis, and neurogenic bladder.</p> <p>The Quarterly MDS, dated 10/13/14, coded the resident had short term/long term memory impairment, required total dependence of two or more staff for toileting, was occasionally incontinent, and was on a toileting program.</p> <p>The Urinary/Bowel elimination care plan and the Infection care plans, dated 2/17/14 to 10/22/14,</p>	F 279	<p>F279</p> <p>Current Residents: Resident # 8's Care Plan has been reviewed by the IDT and updated.</p> <p>Potential New Residents: All new residents will have comprehensive care plans that include measurable objectives and timetables to meet the resident's identified needs. The care plan will be updated as needed by the IDT.</p> <p>New Process: Care plans are reviewed and revised with each MDS assessment process in the IDT meetings held twice per week and with each change of condition.</p> <p>Training: The DNS educated all the IDT staff on the new process.</p> <p>Monitoring: Nursing administration will audit 20% of care plans monthly X3 months to ensure accuracy.</p>	02/20/2015
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F 279	Continued From page 16 documented the following interventions: "Monitor for s/s [signs and symptoms] of UTI, burning, increase in frequency, odor, color, decreased output, retention...Staff to assist [resident] to the toilet before/after meals, HS [bedtime], and PRN; and Straight cath[eter] as ordered using sterile technique to obtain post void residuals after Resident #8 uses the toilet." The initial and current care plan did not document what signs and symptoms should be evaluated for urinary retention; when the resident should be continuously catheterized; the size of the catheter; how to monitor for input/output of fluids; and the evaluation of medications with side effects of urine retention and UTI's. On 1/16/15 at 10:30 AM, the Interim DNS was interviewed and stated the resident's care plans were "canned" and not individualized. She stated the initial care plan for the resident's urinary retention should have included signs/symptoms, treatments, parameters for notification of the physician, and evaluation of the resident's medication for adverse effects, including urinary retention and UTI's. On 1/16/15 at 2:45 PM, the Administrator was notified about the concerns. No further information was provided.	F 279		02/20/2015	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		02/20/2015	

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F 280	Continued From page 17 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 2 of 13 (#s 5 & 10) sampled residents. This failure created the potential for harm if staff were confused about assistance with eating for Resident #5 and for ambulation for Resident #10. Findings included: 1. Resident #5 was admitted to the facility on 9/5/12 with multiple diagnoses, including Alzheimer's, dementia with behavioral disturbances, psychotic disorder with delusions, edema, and obesity. The resident's quarterly MDS assessment, dated 10/10/14, documented the facility could not interview the resident to make this determination, moderately impaired in his daily decision making	F 280	F280 Current Residents: Residents #5 and 10's Assessment and Care Plan have been updated. Potential New Residents: The IDT will complete a comprehensive assessment and care plan within 7 days of admission to meet the individual resident's needs. Assessments are completed quarterly and with significant change thereafter. A care conference is held with the resident/representative to discuss the MDS and Care Plan at the time of admission, on a quarterly basis, and with significant change to get input. Training: DNS educated all IDT members regarding new process. As care plans are updated nurse aides are updated through shift report at the beginning of each shift by the charge RN. Careplans are available to all staff at each nurse's station 24/7. Monitoring: AIT will attend 50% of care conferences to ensure participation of resident/representative and an IDT process. The AIT will ensure the staff is fully educated and aware of the content of the care plan by nursing administration and/or the program coordinator.	02/20/2015	

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
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F 280	<p>Continued From page 18 skills, and limited 1 staff assistance for eating.</p> <p>Resident #5's January 2015 recapitulation Physician's Orders and MAR documented, "FORTIFIED REGULAR DIET. PUREE TEXTURE. HONEY THICK LIQUIDS NURSE TO BE BY RESIDENT EACH MEAL...Origin 4/25/13..." and "...HAVE RESIDENT DO 2 SWALLOWS FOR EACH BITE...Origin 9/20/12..."</p> <p>Resident #5's current Care Plan documented: *Problem: Impaired cognition related to dementia. "...Goals...RECEIVE ADEQUATE CARE...STAFF TO ANTICIPATE NEEDS...REMAIN SAFE...Estimated date 1/22/15...", interventions included, "...VERBAL CUES AS NEEDED...GIVE SIMPLE COMMANDS..." *Problem: Nutritional Risk. "...Goals...ASSIST WITH TRAY SET-UP AS NEEDED...FORTIFIED/PUREE/HONEY THICK LIQUIDS...IS ABLE TO FEED HIMSELF WITH SET UP ASSIST...TENDS TO EAT TOO FAST. STAFF TO CUE [Resident #5] TO SLOW DOWN..."</p> <p>The resident's Speech Therapy Evaluation, dated 4/16/13, documented the resident's long term goal: "...Patient will improve swallow abilities to Min/Close Supervision as evidenced by ability to safely and efficiently swallow least restrictive diet with minimal to absent s/s oral dysphagia...and safely consume least restrictive diet..." The facility did not provide a more current dysphagia evaluation.</p> <p>On 1/13/15 at 8:00 AM and on 1/14/15 at 8:20 AM, Resident #5 was observed in the dining room. The resident on both occasions was being</p>	F 280	02/20/2015

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F 280	<p>Continued From page 19</p> <p>fed his meal by a staff member. The staff member was cuing the resident to chew, slow down, and swallow numerous times with each bite. The resident coughed and made choking sounds throughout the meal.</p> <p>On 1/14/15 at 1:37 PM, the LN who fed the Resident breakfast on the 13th was interviewed, regarding how staff assisted him with meals. LN #3 said the resident's condition had changed and that staff were feeding him. "He eats too fast and needs a lot of cueing. Yes, the Care Plan needs to be updated to reflect this. He's not safe."</p> <p>2. Resident #10 was admitted to the facility on 8/28/12 with multiple diagnoses, including mood disorder, anoxic encephalopathy, hypertension, and edema.</p> <p>The resident's quarterly MDS, dated 10/14/14, documented the resident's cognition was moderately impaired and 2 staff extensive assist was required for transfers, as well as ambulation in the room and corridor.</p> <p>Resident #10's January 2015 recapitulation Physician's Orders and TAR documented, "AMBULATE WITH FWW [front wheel walker] AND 1 ASSIST TO MEALS...Origin 5/24/13..." The resident's TAR did not contain an area for the nursing staff to document the ambulation to meals took place.</p> <p>Resident #10's current Care Plan documented: *Problem: Self-Care Deficit Mobility related to anoxic brain injury exhibited by poor coordination and poor balance. "...Goals...MAINTAIN FUNCTIONAL ABILITY IN AMBULATION/TRANSFERS WITH LIMITED</p>	F 280		02/20/2015	

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F 280	<p>Continued From page 20</p> <p>ASSIST...Estimated date 1/22/15...", interventions included, "...REQUIRES LIMITED-EXTENSIVE ASSIST X [times] 1 WITH MOBILITY/TRANSFERS...USES A W/C FOR LONG DISTANCES...SHE IS TO WALK TO/FROM MEALS WITH A FWW WITH 1 ASSIST AND GAIT BELT... RESTORATIVE PROGRAM PER NURSING/THERAPY RECOMMENDATION..."</p> <p>*Problem: Restorative Therapy related to history of chemotherapy and radiation and a fall risk. "...Goals...MAINTAIN FUNCTIONAL LEVEL IN AMBULATION/TRANSFER WITH LIMITED ASSIST... Estimated date 1/22/15...", interventions included, "...ENGAGE IN SIT TO STAND EXERCISES 5-6 X WK [WEEK]...ENGAGE IN AMBULATION WITH FWW 5-6 X WEEK..."</p> <p>The resident's January 2015 RNA Care Plan Flow Sheet documented the resident did not engage in ambulation with the FWW during any sessions (11 times) from 1/1 through 1/13/15.</p> <p>On 1/14/15 at 8:56 AM, CNA #12 and NA #11 were observed assisting Resident #10 with dressing. The resident was assisted into her wheelchair and the aides wheeled her into the hallway.</p> <p>On 1/14/15 at 9:15 AM, CNA #12 was interviewed regarding Resident #10's ambulation to and from the dining room. The CNA stated she had "never" seen the resident walk to the dining room and she had worked at the facility for more than a year.</p> <p>On 1/15/15 at 9:08 AM, CNA #13 was interviewed about Resident #10's RNA ambulation program. She stated, "Not so great this month. The perfect</p>	F 280		02/20/2015
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F 280	Continued From page 21 scenario would be if I had the resident at 11:10 AM, then I could walk her to the dining room." The CNA said the resident had been more lethargic and unsteady and stated the resident's safety was of foremost concern so the resident had to be alert enough to stand up to the walker, wear a gait belt, be safe enough to walk, which she noted the resident was not. CNA #13 said she reported the resident's decline to the appropriate staff so actions could be taken to address this, but nothing had changed yet to her knowledge. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. No additional information or documentation was provided to resolve the concern.	F 280		02/20/2015	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure: *A resident on dialysis received appropriate care; *A resident with dementia received person appropriate care for psychosocial needs;	F 309 F309	Current Residents: Residents #1, #6, #8, and #10's MDS and Care Plan have been reviewed and updated by the IDT. Potential New Residents: All new residents will receive the necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment and POC. The IDT will follow the new process for managing dialysis residents. The IDT will establish specific goals for behavioral patients and specific goals for Dementia care. The POC addresses specific needs such as: geri-sleeves and TED hose, all staff are educated regarding these needs as new orders are received.	02/20/2015	

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F 309	<p>Continued From page 22</p> <p>*Geri sleeves were worn per physician's order; and,</p> <p>*Therapeutic Embolic Device (TED) hose were worn per physician's order.</p> <p>This affected 4 of 13 (#s 1, 8, 6 & 10) sampled residents. These failures created the potential for the residents to experience complications and/or compromised medical or psychosocial status. Findings included:</p> <p>1. The facility dialysis policy, dated January 2015, documented in its entirety: Policy Statement: The facility will ensure communication between the dialysis center and the long term care center is maintained. Procedure and Implementation: 1. The resident is to be evaluated prior to leaving the facility by the Licensed Nurse. 2. The dialysis worksheet utilized by the facility will be filled out by the licensed nurse. 3. When the resident comes back to the facility the post dialysis form will be completed by the licensed nurse. 4. The licensed nurse will review the dressing and the site of AV [arteriovenous] fistula. Note: The policy did not address or direct staff what to do for specific care areas for residents on dialysis.</p> <p>Resident #1 was readmitted to the facility on 10/26/14 with multiple diagnoses including end stage renal disease.</p> <p>The resident's January 2015 Physician Order Report and TAR both documented an order dated 10/26/14, "Dialysis Mon, Wed, Fri at [Local Dialysis]."</p> <p>A dialysis care plan was not found in the resident's medical record.</p>	F 309	<p>New Processes:</p> <p>Process #1 A new dialysis policy has been created which includes a pre/post form for dialysis residents to be completed by the nurse. This form includes: an assessment of the resident, VS and an assessment of the dressing. In addition, a communication tool is sent with the patient to the dialysis center, this tool is then received back from the nurse taking care of the resident with any follow up directions. Both nurses sign the form for verification.</p> <p>Process #2 The Behavioral Care Unit (BCU) meets on weekly basis to discuss resident needs related to behaviors. This information is then brought to the IDT and goes into the MDS/ Care Plan process.</p> <p>Process #3 A new process has been implemented for the nursing staff regarding TED hose and Geri-sleeves. Each shift the nurse aides complete an audit sheet informing the nurse of the residents they have put TED hose and/or Geri-sleeves on or off, the nurse must sign off on the sheet verifying correctness.</p>	02/20/2015	

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F 309	Continued From page 23 The resident's Post Dialysis Nursing Assessment for Resident with Central Line worksheets from 11/12/14 to 1/12/15 were reviewed and out of 30 possible dialysis entries, there was only one entry completed, dated 11/26/14, which documented: *The time the resident left and returned from the dialysis center; *The resident's post dialysis temperature, pulse, respiration rate, blood pressure; and, *The condition of the dressing site. The resident's Nurse's Notes were reviewed from 11/12/14 to 1/12/15 and out of 30 possible dialysis entries, only one entry on 11/14/14 documented the resident's AV fistula dressing was assessed. On 1/15/15 at 10:15 AM, LN #3 was interviewed regarding the resident's dialysis care. When asked where in the chart would the resident's dialysis care plan could be located, she stated, "It's not in here." She stated she and other LNs knew what to check for when the resident came back from dialysis, but stated, "There's no documentation." #2. Resident #8 was admitted to the facility on 2/5/14 with multiple diagnoses including dementia with behavioral disturbance and psychosis. Federal Regulation F 309, Review of Care and Services for a Resident with dementia defined, "Person-Centered or Person-Appropriate care is care that is individualized by being tailored to all relevant considerations for that individual, including physical, functional, and psychosocial aspects." Individualized Approaches and	F 309	Training: The IDT and BCU team were trained by the DNS regarding the new MDS/Care Plan process. The nurses were trained by the ADNS regarding the dialysis process. All staff were trained by the ADNS regarding the TED hose and Geri-sleeve process. Monitoring: IDT will monitor annual and quarterly MDS/Plan of Care as it relates to necessary care and services regarding the dialysis resident weekly. A member of nursing administration will audit the dialysis sheets to ensure nurse's are completing an assessment of the dialysis resident pre/post dialysis and communicating with the dialysis center weekly X4 weeks, then monthly X3. A member of nursing administration will audit the TED hose and Geri-sleeve binder to ensure CNAs are documenting and reporting the use of geri-sleeves and ted hose weekly X4 weeks, then monthly X3 months.	02/20/2015	

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F 309	<p>Continued From page 24</p> <p>Treatment include, "Identify and document specific target behaviors, expressions of distress and desired outcomes; and Implement appropriate, individualized person-centered interventions..."</p> <p>The Quarterly MDS, dated 10/13/14, coded the resident had "constant inattention and disorganized thinking; had 12-14 days of feeling down, depressed, or hopeless; and 7-11 days of having little interest or pleasure in doing things. The resident identified the following things to be "very important" to her: Having books newspapers, and magazines to read, listening to music, keeping up with the news, doing things with groups of people, and participating in religious services.</p> <p>The initial Behavioral care plan, dated 2/18/14, and each quarterly review thereafter, included the same problem, goal, and interventions. The problem identified documented the resident had/had behaviors related to "dementia exhibited by depression/anxiety, resistive, and verbal behaviors."</p> <p>The initial, reoccurring, and current goal was to "reduce the number of incidents [in the] next 90 days." The goal did not include what specific incidents were to be reduced, the numeric value for decreased incidents, or how the goal would improve the resident's mental and psychosocial well being. The initial, reoccurring, and current interventions included: "Staff to attempt to redirect [Resident #8's] attention when she starts to display s/s of depression/anxiety, offer an activity, switch out staff as needed, additional staff as needed to complete cares, remind [Resident #8] to use her indoor voice, and if [Resident #8] is being disruptive in a common area, staff to assist her to a less congested area." The interventions</p>	F 309		02/20/2015	

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F 309	<p>Continued From page 25</p> <p>did not include what activity should be offered to the resident or what specific redirection was effective when the resident expressed s/s of depression/anxiety. Additionally, it could not be determined how "remind [Resident #8] to use her indoor voice" was an appropriate intervention for a resident displaying s/s of anxiety/depression.</p> <p>On 1/16/15 at 10:30 AM, the Interim DNS stated the Behavior care plan was a "canned" care plan and it did not identify specific goals and interventions related to the resident's identified needs. She confirmed the care plan was unacceptable and said the facility was working on initializing care plans to address each specific resident's needs.</p> <p>3. Resident #6 was admitted to the facility on 12/1/11 with multiple diagnoses including Alzheimer's disease, dementia with behavioral disturbances, disturbance of conduct, and history of cerebrovascular accident (CVA) with mild left sided hemiparesis.</p> <p>The resident's quarterly MDS, dated 11/4/14, documented the resident's cognition was moderately impaired, upper extremity impairment on one side, and extensive 2 staff assist for getting dressed.</p> <p>Resident #6's January 2015 recapitulation Physician's Orders documented, "Geri Sleeves on at all times except to shower...11/08/14..."</p> <p>The resident's December 2014 and January 2015 TARs documented, "...Geri Sleeves on at all times except to shower..." The TARs contained documentation that the resident's geri sleeves</p>	F 309		02/20/2015	

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F 309	<p>Continued From page 26</p> <p>were on the resident for all shifts during this time frame.</p> <p>Resident #6's current Care Plan documented: *Problem: Potential Impaired Skin Integrity related to impaired mobility and requires assist with cares. "...Goals...0 Breakdown in skin...Estimated date 2/7/15...", interventions included, "...Hall nurse to check skin per protocol, treatment nurse to observe, staff to observe skin with showers and toileting..." Note: The resident's Care Plan did not include the geri sleeves.</p> <p>The resident was observed wearing short sleeve T-shirts, without geri sleeves on his arms on 1/13/15 at 8:10 AM and 1:50 PM and on 1/14/15 at 7:40 AM and 9:40 AM, when he was in the dining room, his room, or the hallway.</p> <p>On 1/14/15 at 9:58 AM, CNAs #8 and #9 were interviewed in regards to Resident #6's geri sleeves. CNA #8 stated, "Long time ago he was wearing them." Both CNAs said they were not putting geri sleeves on the resident and thought they had been discontinued months ago.</p> <p>On 1/14/15 at 1:37 PM, an interview was conducted with LN #3 about the surveyor's observations. The LN said the resident did not wear geri sleeves anymore and a new order needed to be written to reflect this.</p> <p>4. Resident #10 was admitted to the facility on 8/28/12 with multiple diagnoses including mood disorder, anoxic encephalopathy, hypertension, and edema.</p>	F 309		02/20/2015	

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F 309	<p>Continued From page 27</p> <p>The resident's quarterly MDS, dated 10/14/14, documented the resident's cognition was moderately impaired and she required 2 staff for limited assist in getting dressed.</p> <p>Resident #10's January 2015 recapitulation Physician's Orders documented, "Geri Sleeves on at all times except to shower...11/17/14..." and "...Knee High Ted hose size large on in AM off at HS [hour of sleep]...8/28/12..."</p> <p>The resident's December 2014 and January 2015 TARs documented, "...Geri Sleeves on at all times except to shower..." and "...Knee High Ted hose size large on in AM off at HS..." The TARs contained documentation that the resident's geri sleeves were in place on all shifts and the resident's Ted hose were in place during the morning shift and removed on the evening shift during this time frame.</p> <p>Resident #10's current Care Plan documented: *Problem: Self-Care Deficit related to anoxic brain injury exhibited by the inability to put on necessary items of clothing. "...Goals...Be appropriately dressed with assistance...Estimated date 1/22/15...", interventions included, "...Requires limited-extensive assist...with dressing..." *Problem: Potential Impaired Skin Integrity related to occasionally incontinent, lacks safety awareness, use of psychotropic drugs and diabetes. "...Goals...O [No] Breakdown in skin...Skin will be clean and dry q [every] shift... Estimated date 1/22/15...", interventions included, "...Ted Hose on in AM off in PM..." and "...Geri-sleeves to arms bilaterally..."</p>	F 309		02/20/2015	

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F 309	<p>Continued From page 28</p> <p>On 1/13/15 at 1:37 PM, Resident #10 was observed in the dining room dressed in a short sleeve shirt and without geri sleeves on her arms.</p> <p>On 1/14/15 at 8:56 AM, CNA #12 and NA #11 were observed, while Resident #10 was assisted with dressing. Neither the CNA nor the NA assisted the resident to put on knee high Teds or geri sleeves. The resident was assisted into her wheelchair and then wheeled into the hallway.</p> <p>On 1/14/15 at 9:15 AM, CNA #12 was interviewed regarding Resident #10's knee high Ted hose and geri sleeves. The CNA stated, "She is supposed to have Ted hose, but they have been lost." CNA #12 said the laundry was supposed to be looking for them and that the resident has not had any Ted hose for at least a week and a half. The CNA said she did not know anything about the geri sleeves and had never put them on the resident.</p> <p>On 1/15/15 at 9:30 AM, the Clinical Care Coordinator (CCC) was interviewed regarding the knee high Ted hose and geri sleeves for Resident #10. The CCC stated the staff had not informed her that the resident's Ted hose were missing and she did not know why the geri sleeves were not on the resident. The CCC said the facility does have replacement stock available and the staff should have replaced the items, if they were unable to find hers.</p> <p>On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. No additional information was provided.</p>	F 309		02/20/2015
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		02/20/2015

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F 314	<p>Continued From page 29</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure 1 of 5 residents (#4) reviewed for pressure ulcers (PU) did not develop a Stage II pressure ulcer on his sacrum. This failed practice created the potential for more than minimal harm if the PU worsened or became infected. Additionally, the facility did not ensure Resident #3 had heel protectors on at all times per the Physician Order. This had the potential for more than minimal harm if the resident developed pain and/or pressure ulcers to his heels Findings included:</p> <p>1. Resident #4 was discharged from the facility on 12/2/14, re-admitted on 12/5/14, discharged on 12/29/14, and readmitted on 1/8/15 with multiple diagnoses, including developmental delay, healthcare associated pneumonia, sepsis, Stage III sacral decubitus ulcer and UTI.</p> <p>The Quarterly MDS, dated 10/14/14, coded the resident had impairment in his bilateral upper and lower extremities and was totally dependent on two or more people for transfers, bed mobility, and toileting.</p>	F 314	<p>F314</p> <p>Current Residents: Residents #3 and 4 have been reassessed and their MDS and Care plans have been revised and update accordingly.</p> <p>Potential New Residents: All new residents are assessed upon admission and receive a skin assessment to determine any skin issues and any special needs at that time. Any residents currently residing in the facility are assessed each time they receive a shower/bath and as needed with significant change and with any Incident/Accident.</p> <p>The Skin Assessment is completed by nurses and the Skin Issue Guidelines for Documentation is followed. All skin concerns are reported to the physician and orders obtained. This process has been approved by the Medical Director.</p> <p>New Process: The Skin/ Wound Nurse works 4 days / week and is responsible for reviewing all skin concerns. The Skin/Wound Nurse works directly with the Medical Director who is a wound specialist and runs the Wound Clinic.</p>	02/20/2015	

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F 314	<p>Continued From page 30</p> <p>The Resident's Nursing Admission Care Plan, dated 12/5/14, documented a problem area of Skin breakdown. Implemented interventions included skin assessment on admit; barrier cream after each episode of incontinence and PRN; High density mattress; and weekly skin assessments. On 12/22/14, "sacral wound" was added to the problem area on the resident's care plan. Interventions included 4 x 4 optifoam Ag [silver] dressing, vitamins and/or minerals, daily evaluation of dressing status and surrounding area, weekly assessment with measurements, and an alternating air mattress with staff turning the resident from side to side on a regular schedule.</p> <p>Skin Assessment Forms, dated 12/5/14 to 12/19/14, documented the following: from 12/5/14 to 12/9/14 a duoderm patch was applied to the resident's sacrum as a preventative measure related to intact fragile skin. On 12/16/14, a 3 cm purple, intact area on the coccyx was identified and an optifoam [dressing] was re-applied. On 12/19/14, the sacral wound opened and the area increased in size to 4 cm. The optifoam dressing was re-applied.</p> <p>The 12/16/14 Skin Assessment Form identified the purple area was on the sacrum, while the 12/19/14 Skin Form documented the open area was on the coccyx. On 1/15/15, the wound nurse confirmed the area was on the sacrum. He stated the nurse who performed the skin assessment on 12/19/14 documented incorrectly.</p> <p>An Incident/Accident Report, dated 12/19/14, documented, "While performing cares it was discovered that the pt's [patient's] optifoam to his</p>	F 314	<p>The IDT meets twice weekly to discuss resident needs including skin issues, the MDS and Care Plan are completed based on the agreed upon needs.</p> <p>Physician orders are obtained for special needs equipment related to skin issues. This equipment is care planned, staff is educated regarding the new orders in the change of shift report meetings and through the daily audit sheets that must be signed for care.</p> <p>A new process has been implemented for the nursing staff regarding heel protectors. Each shift the nurse aides complete an audit sheet informing the nurse of the residents they have put heel protectors on, the nurse must sign off on the sheet verifying correctness.</p> <p>Training: The IDT was educated by the DNS regarding the new MDS/Care Plan process. The nursing staff was educated regarding physician orders, skin assessment processes, special devices and the change of shift meetings by the ADNS. The CNAs were educated regarding the change of shift meetings, special devices, and the audit sheets by the ADNS.</p>	02/20/2015
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F 314	<p>Continued From page 31</p> <p>fragile sacral area was gone and the area had opened up." The intervention implemented was to re-apply the optifoam. The facility identified the root cause as "missing optifoam." At the time the incident report was completed, the open wound on the resident's sacrum was not staged or measured. Three days later, on 12/22/14, when the sacral wound was measured, it was documented as a Stage II pressure ulcer.</p> <p>The Pressure Sore Identification and Progress form, dated 12/22/14, documented the resident had a Stage II pressure ulcer to his sacrum, which measured 1.7 [length] x 2.5 [width] x less than 0.1 [depth].</p> <p>On 12/29/14, the resident was admitted to a local hospital with multiple diagnoses, including "Sacral wound with some surrounding erythema. This may also be a source of infection. Appears to be infected on admission."</p> <p>On 1/15/15 at 6:25 PM, when asked if the interventions had been reviewed and/or revised for appropriateness as the area began to deteriorate on 12/16/14, the wound nurse stated they had not. He stated he was employed part time and it was difficult to keep track of all skin issues when he was only there three days a week.</p> <p>On 1/15/15 at 7:00 PM, the Administrator, Interim DNS, and AIT were informed of the above concern. No further information was provided to resolve this concern.</p> <p>On 1/16/15 at 9:00 AM, the Interim DNS and surveyor reviewed the resident's record and the DNS confirmed the interventions had not been</p>	F 314	<p>Monitoring: IDT will monitor annual and quarterly MDS for accuracy weekly.</p> <p>A member of nursing administration will audit the Special Device binder for accuracy and completion weekly X4 weeks, then monthly X3 months.</p> <p>The Skin/Wound Nurse will monitor all skin sheets weekly.</p>		

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F 314	<p>Continued From page 32 reviewed and/or revised to address the deterioration of the resident's wound.</p> <p>2. Resident #3 was readmitted to the facility on 5/23/14 with multiple diagnoses including diabetes with peripheral circulatory disorders and edema.</p> <p>The resident's Physician Orders, dated 7/30/14, documented, "Place heel in heel protector."</p> <p>The resident's January 2015 Physician Order Report and TAR documented, with an origin date of 7/30/14, "Heel cushions at all times."</p> <p>The resident's Potential Impaired Skin Integrity care plan, with an origin date of 10/14/14, did not include heel protectors or cushions as an intervention.</p> <p>The resident was observed in bed without heel cushions in place on the following dates and times: -1/12/15 at 4:05 PM; -1/13/15: 7:35 AM, 9:35 AM, 12:20 PM, 2:45 PM, 3:50 PM; and, -1/14/15: 8:12 AM, 9:40 AM, 10:45 AM.</p> <p>On 1/14/15 at 1:25 PM, the resident was observed in her wheelchair without heel cushions in place.</p> <p>On 1/15/15 at 1:15 PM, the Clinical Care Coordinator was interviewed. When asked about the orders and informed of the observations, she stated, "If it's not DC'd [discontinued] then it should still be active." She said she would look</p>	F 314		02/20/2015
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F 314	Continued From page 33 into the issue. On 1/15/15 at 2:45 PM, the Clinical Care Coordinator provided a copy of the resident's previous skin care plan found in the resident's overflow chart dated 7/30/14. One of the interventions documented, "heel protectors." She said the intervention was missed when the care plan was updated. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issues. No further information was provided by the facility.	F 314		02/20/2015
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident who had urinary retention received additional evaluation to rule out causative factors such as structural abnormalities, medical conditions, and/or medication use. This was true for 1 of 5 (#8) residents sampled for bladder	F 315	F315 Current Residents: Residents #8 and 13 have been reassessed and their MDS/Care Plan have been updated as needed. Potential New Residents: All new residents are assessed upon admission and any special needs regarding urination and bladder concerns are determined at that time. These special needs are addressed in the MDS and Care Plan. For existing residents, as concerns arise, assessments /POCs are updated accordingly.	02/20/2015

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F 315	<p>Continued From page 34</p> <p>function. Additionally, the facility did not ensure Resident #13 had a care plan in place to address her bladder function after her catheter was removed. These failed practices placed residents at risk for pain/discpnmfort, urinary retention, UTI's, and/or urosepsis. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 2/5/14 with multiple diagnoses including diabetes, chronic kidney disease, urinary tract infection, lumbosacral stenosis, and neurogenic bladder.</p> <p>The Quarterly MDS, dated 10/13/14, coded the resident had short term/long term memory impairment, was on a toileting program, and was occasionally incontinent.</p> <p>Marieb, E. N. (2004). Human Anatomy & Physiology, Sixth Edition. The Urinary System, 25, 1025-1028 documented the urinary bladder holds approximately 500 ml of urine...the maximum capacity of the bladder is 800-1000 ml and when it is overdistended, it may burst. When about 200 mls of urine have accumulated in the bladder a person feels the urge to void. If the urge to void continues and the urine volume exceeds 500-600 mls, voiding becomes "irresistible" and voiding occurs in a person with normal bladder function. After normal voiding occurs, only about 10 mls of urine should remain in the bladder. (p. 1026-1027).</p> <p>The Urinary/Bowel elimination care plan and the Infection care plan, dated from 2/17/14 to 10/22/14, documented the following interventions: "Monitor for s/s [signs and symptoms] of UTI, burning, increase in frequency, odor, color, decreased output, retention...Staff to assist</p>	F 315	<p>New Process: The IDT meets twice weekly to discuss resident needs including urinary/catheter issues, the MDS and Care Plan are completed based on the agreed upon needs.</p> <p>A new form for documenting PVRs has been established and implemented to ensure accuracy of communication regarding resident's output and follow-up.</p> <p>Training: The IDT was educated by the DNS regarding the new MDS/Care Plan process.</p> <p>The nursing staff was educated regarding physician orders, urinary/bladder assessment processes, PVR form and documentation by the ADNS.</p> <p>The CNAs were educated regarding the importance of reporting output by the ADNS.</p> <p>Monitoring: IDT will monitor annual and quarterly MDS for accuracy weekly.</p> <p>A member of nursing administration will audit the PVR sheets weekly x4 weeks, then monthly X3.</p>	02/20/2015	

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F 315	<p>Continued From page 35</p> <p>[resident] to the toilet before/after meals, HS [bedtime], and PRN; and Straight cath[eter] as ordered using sterile technique to obtain post void residuals after Resident #8 uses the toilet."</p> <p>The initial and current care plan did not document, what signs and symptoms should be evaluated for urinary retention; when the resident should be continuously catheterized; the size of the catheter; how to monitor for input/output of fluids; and the evaluation of medications with side effects of urine retention and UTI's.</p> <p>The Physician Order Report, dated 1/1/15, documented, the resident received the following medications, Abilify, Ativan, Trazodone, Namenda, and Neurontin. Each medication was identified to have an adverse effect of urinary retention and/or UTI.</p> <p>The Physician's Orders documented, an order for the resident to be straight catheterized every 8 hours/PRN; and post void residuals every shift.</p> <p>The current care plan and current Physicians Orders were not consistent. The resident's toileting program per the care plan was before/after meals, at bedtime and as needed. Additionally, PVRs were to be checked after each time the resident used the toilet. The Physician's Order documented PVRs once a shift.</p> <p>A Urology consult report, dated 8/5/14, documented the resident's chief complaint was, "I am unable to urinate." The Physician documented the following note, "Patient with suspected urinary retention. However, she does not have very many infections, and she urinates well. She does, however, have the frequent urgency to urinate</p>	F 315		02/20/2015	

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F 315	<p>Continued From page 36</p> <p>and frequency and cannot go despite this. PVRs were not measured as requested. She is catheterized three times a day. There is no record of how much is catheterized. Therefore, the facility is requested to measure true post-void residuals for a few days; [This] should be performed right after she urinated. This data may be faxed over to be evaluated. Any further treatment planning is decided [sic] on the basis of this."</p> <p>It was unclear how the physician determined the resident "urinated well" when the chief complaint was an inability to urinate, she required straight catheterization multiple times per day, and there was no quantitative data to determine the resident's output.</p> <p>Federal Regulation F 315, Urinary Incontinence documented, "Overflow Incontinence occurs when the bladder is distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. In overflow incontinence, PVR volume (the amount of urine remaining in the bladder within 5 to 10 minutes following urination) exceeds 200 milliliters (ml). Normal PVR is usually 50 ml. or less. A PVR of 150 to 200 may suggest a need for retesting to determine if this finding is clinically significant. Sterile insertion and removal of a catheter every 3-6 hours for bladder drainage may be appropriate for the management of acute or chronic urinary retention."</p> <p>The resident's November 2014 average post void residuals (PVR) included: * Day Shift - 428.33 cc's of urine;</p>	F 315		02/20/2015	

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F 315	<p>Continued From page 37</p> <ul style="list-style-type: none"> * Evening Shift - 516.66 cc's of urine; and * Night Shift - 594.16 cc's of urine. <p>During the month of November 2014, the PVR flow sheet documented:</p> <ul style="list-style-type: none"> * Day Shift - the resident had 9 days when her PVR was 500 mls or greater; * Evening Shift - the resident had 18 days when her PVR was 500 mls or greater; and * Night Shift - the resident had 21 days when her PVR was 500 mls or greater. <p>The resident's December 2014 average PVR's included:</p> <ul style="list-style-type: none"> * Day Shift - 463.87 cc's of urine; * Evening Shift - 359.67 cc's of urine; and * Night Shift - 474.67 cc's of urine. <p>During the month of December 2014, the PVR flow sheet documented:</p> <ul style="list-style-type: none"> * Day Shift - the resident had 15 days when her PVR was 500 mls or greater; * Evening Shift - the resident had 7 days when her PVR was 500 mls or greater; and * Night Shift - the resident had 15 days when her PVR was 500 mls or greater. <p>On 1/16/15 at 10:15 AM, when asked if the pharmacist, physician, and the facility had reviewed the resident's medications for adverse effects to include urinary retention, the DNS stated she did not think so, but could not be certain. The DNS said the medications should have been reviewed. When asked if the nursing staff was following the care plan or the physician's orders for catheterizing the resident, the DNS stated she did not know. The DNS said based on the resident's PVRs and diagnosis of neurogenic bladder the resident should have</p>	F 315		02/20/2015	

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F 315	<p>Continued From page 38</p> <p>been evaluated for an indwelling or suprapubic catheter. The DNS confirmed the PVRs were not acceptable and she verbalized concerns related to the resident developing acute renal failure and/or urosepsis. When asked if the care plan addressed the resident's individualized needs related to urinary retention, the DNS stated the care plan was "canned" and not individualized. When asked if the facility provided the urologist with the requested information and if the resident had a follow-up visit with the urologist, the DNS said there was nothing in the resident's record to indicate either was done.</p> <p>On 1/16/15 at 2:45 PM, the Administrator was notified about the above concerns. No further information was provided.</p> <p>2. Resident #13 was originally admitted to the facility on 12/20/12 and readmitted on 8/15/14 with multiple diagnoses including multiple sclerosis; contractures of the knee, hip, and ankle; and chronic pain.</p> <p>Resident #13's most recent annual MDS assessment, dated 11/13/14, coded: *Moderately impaired cognitive skills; *Total assistance of 2+ for transfers and toilet use; *Indwelling catheter; *Always incontinent of bowel; and *No trial toileting program.</p> <p>The resident's Physician Orders documented on 11/21/14: "...D/C [discontinue] foley - Frequent UTIs [urinary tract infections]..."</p> <p>Resident #13's Nurse's Notes documented on</p>	F 315		02/20/2015	

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F 315	Continued From page 39 11/21/14 at 12:30 PM: "...DC foley...", and on 11/21/14 at 10:00 PM: "...inc. [incontinent] of urine X [times] 2..." Resident #13's Care Plan documented: *Problem: Self-Care Deficit-Mobility related to Multiple Sclerosis as exhibited by inability to walk and inability to move independently with an origin date of 11/18/14. "...Goals...MAINTAIN FUNCTIONAL ABILITY...", interventions included, "...IS DEPENDENT ON STAFF FOR MOBILITY/TRANSFERS...DOES NOT GET OOB [out of bed] EXCEPT TO SHOWER." *Note: The resident's current Care Plan did not document directions for staff regarding her bladder/urinary incontinence care. On 1/15/15 at 9:30 AM, the Clinical Care Coordinator (CCC) was interviewed in regards to the lack of a bladder/incontinence Care Plan for Resident #13. The CCC stated the resident had a foley catheter in November and because of the history of frequent UTIs, the resident's physician ordered the foley catheter to be discontinued. The CCC said the resident's catheter was removed on 11/21/14 and the facility discontinued the foley catheter Care Plan. The CCC was not aware the facility failed to develop a Care Plan for the bladder/urinary incontinence following the discontinuance of the foley catheter. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. No additional information was provided.	F 315		02/20/2015	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318	F318 Current Residents: Residents # 4 and 6's assessment and POC have been reviewed and updated accordingly.	02/20/2015	

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F 318	<p>Continued From page 40</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure 2 of 3 (#s 4 and 6) sampled residents with range of motion (ROM) limitations were provided a RNA program and appropriate treatment with the utilization of a carrot for a hand contracture. This deficient practice created the potential for further decline in their physical abilities. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 12/1/11 with multiple diagnoses including Alzheimer's disease, dementia with behavioral disturbances, and a history of a cerebrovascular accident (CVA) with mild left sided hemiparesis.</p> <p>The resident's quarterly MDS, dated 11/4/14, documented moderately impaired cognition and upper extremity impairment on one side.</p> <p>Resident #6's January 2015 recapitulation. Physician's Orders documented, "...CARROT TO L. [left] HAND FOR CONTRACTURE...9/26/12..." NOTE: The device called a "carrot" is an orange cloth covered squeezable object, shaped like a carrot, thicker at the top and tapers to thinner at the opposite end.</p>	F 318	<p>Potential New Residents: All new residents are assessed upon admission and any special needs regarding limited ROM are determined at that time. These special needs are addressed in the MDS and Care Plan. For existing residents, as concerns arise, assessments /POCs are updated accordingly.</p> <p>New Process: A new process has been implemented for the nursing staff regarding carrots and other special devices. Each shift the nurse aides complete an audit sheet informing the nurse of the residents they have put special devices on, the nurse must sign off on the sheet verifying correctness.</p> <p>The facility has put a new position into place: "The Program Coordinator" – the employee who has been placed in this position is coordinating the RNA Program, educating the CNAs on the programs in place and ensuring compliance with the provision of care.</p> <p>Training: The IDT was educated by the DNS regarding the new MDS/Care Plan process.</p> <p>The nursing staff was educated regarding special devices form and documentation by the ADNS.</p>	02/20/2015	

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F 318	<p>Continued From page 41</p> <p>The resident's January 2015 MAR documented, "...CARROT TO L HAND FOR CONTRACTURE...INFO...9/26/12..." The MAR did not contain an area for nursing staff to document daily if the carrot was in place.</p> <p>Resident #6's current Care Plan documented: * Problem: Self Care Deficit-Mobility related to generalized weakness exhibited by impaired coordination, inability to walk, difficulty to propel own wheelchair, and impaired balance. "...Goals...MAINTAIN CURRENT LEVEL OF MOBILITY TO TRANSFER WITH ASSIST...NO NEW CONTRACTURES...Estimated date 2/7/15...", interventions included, "...RESTORATIVE PROGRAM PER NURSING RECOMMENDATION...USES A W/C [wheelchair] AT THIS TIME AND IS ABLE SELF PROPEL..." * Problem: Contracture related to Immobility exhibited by contracture of left hand. "...Goals...EXISTING CONTRACTURES WILL NOT WORSEN...Estimated date 2/7/15..." Intventions included, "...RESTORATIVE PROGRAM...CARROT TO LEFT HAND..."</p> <p>The resident's December and January 2015 RNA Care Plan Flow Sheet documented: "...ENSURE CARROT TO L HAND IS IN PLACE CHECK SKIN WASH AND DRY HAND AND REPLACE CARROT. GENTLE ROM AS TOLERATED..." The flow sheet was signed daily by the RNA staff on Mondays through Fridays and the minutes were documented as 5 minutes for each day.</p> <p>The resident's left hand was observed without a carrot in place on multiple occasions and on 1/13/15 at 8:10 AM and 1:50 PM and on 1/14/15 at 7:40 AM and 9:40 AM, when he was observed</p>	F 318	<p>The CNAs were educated regarding the importance special devices and documentation by the ADNS.</p> <p>The Program Coordinator educated both the RNA and the CNA staff on the Restorative Program, the importance of the program, and the role they each play in the program.</p> <p>Monitoring: IDT will monitor annual and quarterly MDS for accuracy weekly.</p> <p>A member of nursing administration will audit the Special Device binder for accuracy and completion weekly X4 weeks, then monthly X3 months.</p> <p>The Program Coordinator will monitor the floor daily for compliance with Restorative Programs and use of devices weekly.</p>	02/20/2015

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F 318	<p>Continued From page 42</p> <p>in the dining room, his room, or the hallway. During those observations, the hand was firmly grasped into a fist with the thumb protruding out.</p> <p>On 1/14/15 at 9:58 AM, CNAs #8 and #9 were interviewed in regards to Resident #6's carrot. CNA #8 stated, "Yes, we know it's supposed to be in place, but he throws them and hides them." Both CNAs said they reported this behavior in their "Behavior Narratives" for report and told the nursing staff about the removal of the carrot and hiding it, but they did not know if this information was ever documented in the resident's clinical record.</p> <p>On 1/14/15 at 1:37 PM, LN #3 said the resident would have the carrot placed in his hand by the CNAs or LNs first thing in the morning and he would remove it and either toss the carrot or hide it. LN #3 did not know if the floor staff had documented the refusal of the carrot, but that the RNA would have documented any non-use. The LN was unsure if any other alternatives had been considered.</p> <p>On 1/16/15 at 9:15 AM, Resident #6 was observed sitting in his wheelchair with the carrot in his left hand.</p> <p>On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. No additional information was provided. 2. Resident #4 was discharged from the facility on 12/29/14, and re-admitted on 1/8/15, with multiple diagnoses, including developmental delay, healthcare-associated pneumonia, sepsis, Stage III sacral decubitus ulcer, and UTI.</p> <p>The Quarterly MDS, dated 10/14/14, coded the</p>	F 318		02/20/2015

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F 318	<p>Continued From page 43</p> <p>resident required total assistance of two or more people for transfers, bed mobility, and toileting, and presented with bilateral impairment of his upper and lower extremities.</p> <p>CMS's RAI Version 3.0 Manual, Section O - O500, page O-37 documented the following, "Measurable objective and interventions must be documented in the care plan and in the medical record. Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity."</p> <p>The Restorative care plan flow sheets were reviewed for October, November, and December 2014 and documented the following: PROM to bilateral upper and lower extremities 5-6 times a week, and communication to stimulate cognitive thinking and lifetime interests. The restorative program did not identify what specific PROM exercise would be performed on the resident's upper and lower extremities and how the restorative aide was to stimulate cognitive thinking and lifetime interests for a resident who had limited movement and severely impaired cognition.</p> <p>On 1/16/15 at 9:30 AM, when asked if the current RNA program was individualized to address the resident's contractures, the Interim DNS stated it was not and the program "was beyond the resident's ability and not specific to his hands." The Interim DNS/MDS Coordinator/ Restorative Nurse identified she had been in the facility for approximately one month and had not been involved in the development or implementation of the resident's restorative care plan.</p>	F 318		02/20/2015	

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F 318	Continued From page 44	F 318		02/20/2015
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure harmful chemicals were secured in an unlocked closet and a newly constructed nurses station in the Cape May unit. This was true for 1 of 1 unfinished closets and 1 of 2 nurses stations in the Cape May unit. This failure created the potential for harm for any independently mobile, cognitively impaired resident who could access the unsecured chemicals. Findings included:</p> <p>1. On 1/12/15 at 1:25 PM, a newly constructed unfinished closet in the Cape May unit was observed. The closet had a door with a lock on it, but the locking mechanism had been taped open making the closet accessible. Inside the closet in</p>	F 323	<p>F323 Current Residents: All residents on the Cape May unit could have been at risk.</p> <p>Potential New Residents: Any new resident would have the potential to be at harm if chemicals were left unattended.</p> <p>New Process: The construction crew has been severely reprimanded and educated regarding the dangers of their chemicals and tools being left unattended. Construction is near completion.</p> <p>Daily Environmental Rounds have been implemented.</p> <p>Training: Staff have been educated to immediately secure construction crew chemicals and tools left unattended.</p> <p>Monitoring: Daily Environmental Rounds Sheets are completed by the supervisor of Housekeeping to ensure a safe and clean environment.</p>	02/20/2015

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F 323	Continued From page 45 a box on the floor on top of plastic pipe fittings, contained a can of "Weld-On" poly pipe primer. The can documented, "Danger: Extremely Flammable. Vapor harmful. May be harmful if swallowed. May irritate skin or eyes." On 1/12/15 at 1:32 PM, LN #3 was shown the closet and pipe primer and said, "I don't know why it's not locked." She then removed the can. 2. On 1/12/15 at 1:37 PM, the newly constructed unfinished nursing station in the Cape May unit was observed. On the floor in the hallway and just outside of the nurses station were two unattended plastic buckets. Inside one of the buckets was a bottle of stain remover that documented on its label, "Danger: Harmful or fatal if swallowed. Vapor harmful. Eye irritant." The other bucket contained a solvent cleaner that documented on its label, "Danger! Extremely Flammable liquid and vapor." On 1/12/15 at 1:40 PM, LN #3 was shown the buckets and she immediately removed them from the area. On 1/13/15 at 5:15 PM, the Administrator, AIT, ADNS, and Clinical Care Coordinator were informed of the hazards. No further information was provided by the facility.	F 323		02/20/2015	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328	F328 Current Residents: Resident # 12's assessment and POC was reviewed and updated accordingly. Resident #17, 19, and 20 continue to have orders for oxygen. Resident #1 assessment and POC have been updated to reflect his needs regarding his ostomy care. The nurse changes his wafer and bag per order and PRN, the nurse aide staff encourage independent care, and provide assistance as needed.	02/20/2015	

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F 328	<p>Continued From page 46</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility did not ensure three residents' portable oxygen tanks were full and one resident's portable oxygen tank was turned on. This was true for 1 of 13 sampled residents (#12) and 3 of 13 random residents (#'s 17, 19, & 20). This deficient practice created the potential for harm should residents have a drop in oxygen saturations causing them to become anxious, confused and/or experience respiratory distress. Additionally, the facility did not ensure Resident #1 had an ileostomy care plan to direct staff how to care for and maintain the ileostomy. This had the potential for more than minimal harm if the resident developed discomfort, infection, or skin break down. Findings included:</p> <p>On 1/14/15 from 10:45 AM to 11:15 AM, Resident #12 and Random Residents [RRs] #17 & #20 were observed in their geri-chairs parked on the Cape Elizabeth hall near the nurses station. Each of the three residents had a portable oxygen tank attached to his/her geri-chair and the tanks were observed by the surveyor to be empty. Resident #19 was observed in her wheel chair with a portable oxygen tank, the nasal cannula in her nose, and the tank in the off position.</p>	F 328	<p>Potential New Residents: All new residents are assessed upon admission and any special needs regarding oxygen and ostomies are determined at that time. These special needs are addressed in the MDS and Care Plan. For existing residents, as concerns arise, assessments /POCs are updated accordingly. New Process: The IDT meets twice weekly to discuss resident special needs including oxygen the MDS and Care Plan are completed based on the agreed upon needs. Oxygen tanks are filled at the beginning of each shift on the first round and checked with each round that is made by the CNA staff every 2 hours. The IDT meets twice weekly to discuss resident special needs including ostomy the MDS and Care Plan are completed based on the agreed upon needs. As Care Plans are changed based on new orders and updates, the staff is educated regarding the new orders in the change of shift report meetings.</p> <p>A new process of shift report was initiated at the beginning of each shift. The charge RN gives report to the CNAs, updating them on the care of the residents and any changes that have been initiated. Care plans are changed based on new orders and updates, the staff is educated regarding the new orders in the change of shift report meetings.</p>	02/20/2015	

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F 328	<p>Continued From page 47</p> <p>On 1/14/15 at 11:20 AM, the Clinical Care Coordinator (CCC) was asked and confirmed the portable oxygen tanks for RR's #12, 17, & 20 were empty. The CCC was asked to check RR #19's oxygen saturation and stated it was 83 percent on room air and verified the oxygen tank was in the off position. The CCC turned RR #19's oxygen on at 2 LPM and the resident's oxygen saturation rose to 96 percent. The CCC was unable to provide an explanation for the empty oxygen tanks and the oxygen tank in the off position.</p> <p>Each resident's Physician Order Flow Sheet was reviewed and documented each of the identified residents had the following oxygen order: "Oxygen 2-5 LMP per NC cont[inuuous]. May titrate to keep [oxygen] sat[urations] [greater] than 90 percent."</p> <p>On 1/14/15 at 4:45 PM the Administrator was notified of the above concerns. No further information was provided.</p> <p>2. Resident #1 was readmitted to the facility on 10/26/14 with multiple diagnoses including a history of Ileostomy and end stage renal disease.</p> <p>The resident's quarterly MDS assessment, dated 10/16/14, documented the resident was cognitively intact with a BIMS of 15.</p> <p>The resident's History and Physical, dated 3/18/14, documented, "He has a high-output Ileostomy."</p> <p>The resident's January 2015 Physician Order Report and TAR both documented an order,</p>	F 328	<p>Training:</p> <p>The IDT was educated by the DNS regarding the new MDS/Care Plan process.</p> <p>The nursing staff was educated regarding ostomy needs and documentation by the ADNS.</p> <p>The nursing staff and the CNAs were educated regarding the morning report meeting and the importance of updates of resident care issues by the ADNS.</p> <p>The CNAs will be educated by the Program Coordinator regarding the importance of special devices: such as oxygen and the process of 2 hour checks.</p> <p>Monitoring: IDT will monitor annual and quarterly MDS for accuracy weekly.</p> <p>The Program Coordinator monitors daily the nurse aide staffing to ensure that all oxygen is filled, placed on the appropriate resident's and set at the appropriate liter usage, on an ongoing basis.</p> <p>The Program Coordinator monitors on a weekly basis, the nurse aide staffing to ensure that ostomy care is provided to residents requiring assistance, weekly x4 weeks, then monthly x4 months.</p>	02/20/2015	

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F 328	Continued From page 48 dated 10/28/14, "Change wafer & Ileostomy bag Q [every] 3 days & PRN." An Ileostomy or bowel care plan was not found in the resident's medical record. On 1/13/15 at 9:10 AM, the resident's Ileostomy bag was observed while the resident sat in his wheelchair in his room. At 2:53 PM, the resident was observed to open his room door and called out to staff that he needed assistance to empty his Ileostomy bag. He had exam gloves on his hands and a CNA went into the room to assist the resident. On 1/15/15 at 10:15 AM, LN #3 was interviewed regarding the resident's Ileostomy care. When asked where in the chart would the resident's Ileostomy or bowel care plan be, she looked through the chart and stated, "Not sure." On 1/16/15 at 10:40 AM, the DNS stated the facility did not have a colostomy or Ileostomy policy in place. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issues. On 1/20/15 at 9:28 PM, the facility faxed a copy of the facility Ostomy Care Policy and Procedure, dated 1/20/15. The information did not resolve the previous concern.	F 328		02/20/2015	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	F329 Current Residents: Resident #8's assessment and POC have reviewed and updated accordingly.	02/20/2015	

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F 329	<p>Continued From page 49</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, it was determined the facility failed to ensure behaviors were adequately monitored for the use of an antipsychotic medication. This was true for 1 of 8 (#8) sampled residents reviewed for antipsychotic medication use. In addition, Resident #9 was administered a dementia medication which did not include a diagnosis for its use. This failed practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p>	F 329	<p>Potential New Residents: All new residents are assessed upon admission and a comprehensive assessment and POC is completed. The facility has a Psychotropic Drug Review team (PDR) that meets weekly to review medications to ensure appropriate use, to implement gradual dose reduction, behavioral interventions, and to document appropriately in the record.</p> <p>New Process: A new DNS was put into place in December and she has implemented a new IDT process for handling the PDR, which includes her attendance. Other attendees include but is not limited to: a provider, a pharmacist, a psychiatric nurse specialist, and the program director. The BCU program director is now involved in the PDR so that he can bring to the meeting information regarding repetitive behaviors reported by CNAs and take information back to the CNAs and 1:1s for educational and training purposes.</p> <p>The PDR will be used to evaluate behaviors and use of medications for both need and accuracy. The PDR helps to determine when behaviors are relate to psychotropic drug use or when there is a need to look at medical issue rather than focusing on behavioral concerns. At that time if determined a medical necessity the resident is referred to the medical provider for further evaluation.</p>	02/20/2015	

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F 329	<p>Continued From page 50</p> <p>Resident #8 was admitted to the facility on 2/5/14 with multiple diagnoses including dementia with behavioral disturbance, depression, and psychosis.</p> <p>The Physician Order Report, dated 1/1/15, documented, Ativan 1 mg BID for anxiety; Trazodone 150 mg at bedtime for sleep; Abilify 10 mg every day for depressive disorder; and Namenda XR 28 mg every day for dementia.</p> <p>The Behavior care plan, dated 1/22/15, documented the following interventions: Staff attempt to redirect Resident #8's attention when she starts to display s/s of depression/anxiety; offer an activity; switch out staff as needed; reapproach and redirect as often as needed; and remind Resident #8 to use her "indoor voice."</p> <p>A Social Service Family Care Conference with the resident's POA on 10/6/14 documented the POA expressed concerns related to staff ignoring the resident when she called out to use the bathroom. The POA identified the resident enjoys listening to Broadway and classical music and having poetry read to her.</p> <p>The Social Service Progress notes were reviewed and included only two entries, one dated 10/21/14, which documented the resident was "calm [and] pleasant as we spoke briefly... and she remained very calm during our short visit." The note dated 1/13/15 did not refer to behavioral issues, but documented concerns related to missing clothes.</p> <p>The Psychotropic Drug Re-Evaluation and Assessment (PDR) reviewed for 10/14/14 and 1/8/15 documented "...the resident continues to</p>	F 329	<p>Training:</p> <p>The IDT was educated by the DNS regarding the new MDS/Care Plan process and the PDR process.</p> <p>The nursing staff was educated regarding unnecessary drugs, behaviors related to these drugs, signs and symptoms to report and document by the DNS/ADNS.</p> <p>Monitoring:</p> <p>PDR Team will monitor psychotropic medication changes made x4 weeks, then monthly x2 months</p>	02/20/2015	

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F 329	<p>Continued From page 51</p> <p>demonstrate the behavior of yelling out stating, 'Help me - help me- I need to pee' or just, 'Help me - help me.'"</p> <p>The monthly behavior flow sheets, reviewed for October, November, December 2014, and January 2015, identified the resident's behaviors were, disruptive noises/yelling and attempts to self transfer. Multiple interventions were identified however assessment of the resident's need to void was not included. (Please refer to F315).</p> <p>The resident's November 2014 average post void residuals (PVR) included:</p> <ul style="list-style-type: none"> * Day Shift - 428.33 cc's of urine; * Evening Shift - 516.66 cc's of urine; and * Night Shift - 594.16 cc's of urine. <p>During the month of November 2014, the PVR flow sheet documented:</p> <ul style="list-style-type: none"> * Day Shift - the resident had 9 days when her PVR was 500 mls or greater. On each of those 9 days the monthly behavioral flow sheet (MBFS) documented the resident had a behavior of disruptive noises/ yelling. On 6 of those days, the resident attempted to self transfer anywhere from 1 to 20 times. * Evening Shift - the resident had 18 days when her PVR was 500 mls or greater. For 20 of those evening shifts, the (MBFS) documented the resident had a behavior of disruptive noises/yelling. On 7 of those evening shifts, the resident attempted to self transfer anywhere from 10 to 35 times. * Night Shift - the resident had 21 days when her PVR was 500 mls or greater. For 17 of those night shifts, the (MBFS) documented the resident had a behavior of disruptive noises/yelling. On 2 of those night shifts, the resident attempted to 	F 329		02/20/2015
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F 329	<p>Continued From page 52 self transfer 5-6 times.</p> <p>On 1/16/15 at 9:30 AM, when asked if the facility had attempted GDR's on the Ativan, Trazodone, and Abilify, the Interim DNS stated she was unable to locate that information. When asked if the facility had identified the resident's need to void as a contributing factor to the identified behaviors, the DNS stated she had only been in the facility a month and stated the resident's record did not indicate that had been addressed. When asked if the behavioral interventions were individualized for Resident #8, the DNS stated the care plan used "canned" language and was not individualized. When asked if the resident making "disruptive noises, yelling, and/or attempting to self transfer" could be related to her excessively high PVRs, the DNS said, "Absolutely."</p> <p>On 1/16/15, at 3:00 PM the Administrator was notified related to the above concern. No further information was provided.</p> <p>3. Resident #9 was readmitted to the facility on 9/29/14 with multiple diagnoses including traumatic brain injury and dementia.</p> <p>The resident's 11/11/14 faxed Physician's Order documented an order for Namenda XR 28 MG once a day.</p> <p>The resident's January 2015 Physician Order Report and MAR documented an order for Namenda XR 28 MG once a day.</p> <p>The medical diagnosis for the medication was not found on the order, Physician Order Report or the</p>	F 329		02/20/2015
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F 329	Continued From page 53 MAR. On 1/15/15 at 10:07 AM, LN #3 was interviewed regarding the medication. When asked what the indication for its use was, she looked at the MAR and stated, "...it doesn't say." On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issues. No further information was provided by the facility.	F 329		02/20/2015
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure 4 sampled- and random residents (#s 4, 8, 21, and 29) were free from medication errors. The failure created the potential for less than optimum benefit from prescribed medications when the medications were not administered as ordered. The facility's medication error rate was 43.3%. Findings include: 1. Resident #4's Physician Orders, dated 1/8/15, documented, "Imipenem-cilastatin reconstitute solution 500 mg IV Q [every] 6 hrs [for] 7 days." On 1/14/15 at 10:30 AM, RN #5 was observed to review the MAR for the administration time of the Imipenem-cilastatin antibiotic. RN #5 determined	F 332	F332 Current Residents: Residents #4, 8, 21, and 29 medications have been reviewed and the residents' medications times have been adjusted based on the new schedule set for the units. Potential New Residents: All new residents will follow the new schedule for medications. New Process: The facility has changed the medication pass process to allow nurses a more organized and timely process so that residents will receive medication within the prescribed time frame so as to receive the optimum benefit from the prescribed medications. The medication carts and medication cabinets have been organized so that nurses can readily find what they need. The previous disorganization of medications	02/20/2015

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F 332	<p>Continued From page 54</p> <p>the antibiotic was scheduled for 7:00 AM and it had not yet been administered. The surveyor asked the RN why the 7:00 AM dose had not been given. The RN stated she had been doing other things and was not sure what time the antibiotic was scheduled. The RN stated she would fill out a medication error form and contact the pharmacy to adjust the times for administration of the remaining antibiotic.</p> <p>On 1/14/15 at 1:30 PM, the Interim DNS was informed about the delayed administration of the IV antibiotic medication and confirmed it was a medication error. She stated she could not explain why the antibiotic had not been administered at the scheduled time.</p> <p>2. Resident #8's Physician Orders, dated 1/1/15, documented, "Levothyroxine 50 mcg po [by mouth] Q AM." The manufacture's specification for administration per Pfizer Laboratories documented, "Should be taken in the morning on an empty stomach, at least one-half hour before any food is eaten." On 1/14/15 at 8:15 AM, Resident #8 was observed eating her breakfast in her room and at 8:50 AM, LN #6 was observed to administer Resident #8's Levothyroxine. On 1/14/15 at 1:30 PM, the Interim DNS was informed about the delayed administration of the Levothyroxine and confirmed the medication should have been given prior to the resident eating breakfast.</p> <p>3. Resident #21's Physician Orders, dated 1/1/15, documented, "Morphine Sulfate ER 15 mg po twice a day." The Physician Order Flow sheet identified the Morphine was to be given at 7:00 AM and 5:00 PM. On 1/14/15 at 10:30 AM, LN #6 was observed</p>	F 332	<p>Continued from page 54</p> <p>all throughout the cart caused the nurses to spend a great deal of time searching for medications. A phlebotomist was hired to do lab work and finger-sticks that require a grave amount of time, time that was previously taken away from medication administration Levothyroxine was previously scheduled at 7:00AM, and administered by the dayshift nures. The dayshift nurse was in report until 6:30AM and was unable to deliver the medication on time. Those medications have been moved to a scheduled time for the night shift nurse. All medication have been set up on a new system of delivery times. These time frames are set to allow for meal times, scheduled pain meds, coumadins, and meet the specific needs of the resident. The rn charge nurse has been assigned the responsibility of iv-therapy for both the dayshift and the evening shift. This allows the floor nurse to focus on the medication pass and not be interrupted to hang an IV. All new nurses and new graduate nurses are no longer placed on the floor without an extensive orientation, including a medication pass review and check off.</p>	02/20/2015	

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F 332	<p>Continued From page 55</p> <p>administering the 7:00 AM dose of the morphine to the resident. LN #7 was asked about the delay in administration and she said she was responsible for medicating 30 residents on Cape Elizabeth and she could not get everyone medicated at their scheduled times.</p> <p>On 1/14/15 at 1:30 PM, the Interim DNS was informed about the delayed administration of the morphine and stated it should have been given at the scheduled time. She said it was not possible for one nurse to medicate 30 residents who all had the same scheduled times for medication administration. She stated Cape Elizabeth needed another medication nurse and she would be working on that.</p> <p>4. Resident #29's Physician Orders, dated, 1/1/15 documented, "Levothyroxine 112 mcg po Q [every] AM."</p> <p>On 1/14/15 at 9:10 AM, LN #6 was observed to administer Resident #29's Levothyroxine, after the resident had eaten breakfast.</p> <p>On 1/14/15 at 1:30 PM, the Interim DNS was informed about the delayed administration of the Levothyroxine and confirmed the medication should have been given prior to the resident eating breakfast.</p> <p>On 1/15/15 at 8:15 AM, the Administrator was informed about the concern. No further information was provided.</p> <p>5. On 1/14/15 at 11:15 AM, the following was observed during the Medication Administration Observation:</p> <p>A. Resident #3 had 17 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Lantus insulin and Glipizide for diabetes, Furosemide for edema, Amlodipine and Metoprolol for hypertension, Toviaz for overactive bladder, and Lyrica for pain.</p>	F 332	<p>The recaps/MARs/TARs were cleaned up and reorganized. The MARs/TARs were reprinted by the HIM Director.</p> <p>The night shift is now filling the cart, keeping it cleaned and organized.</p> <p>Training: All nurses were trained on the new medication pass, the NOC shift clean and fill system, the phlebotomy process, and the change-over process by the ADNS and the HIM Director.</p> <p>The phlebotomist were trained on the fingerstick and the lab draw processes by the ADNS.</p> <p>Monitoring: The ADNS will do two medication pass audits per week X6 months. All nurses will be audited 2x per year.</p>	02/20/2015
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F 332	<p>Continued From page 56</p> <p>B. RR #21 had 8 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Norco for pain and Paroxetine for depression.</p> <p>C. RR #22 had 10 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Diltiazem ER for heart arrhythmia, Lasix for COPD, Depakote ER and Zyprexa for schizophrenia, and Lactulose for hyperammonemia.</p> <p>D. RR #23 had 8 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Glipizide for diabetes, Depakote and Seroquel for psychosis, and Namenda XR for dementia.</p> <p>E. RR #24 had 12 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Omeprazole for GERD, Diltiazem for atrial fibrillation, Lasix for edema, Flecainide for cardiac dysrhythmia, and Latuda for schizophrenia.</p> <p>F. RR #25 had 14 medications scheduled for 7:00 AM and at 11:15 AM the resident had not yet received the identified medications, including Glyburide for diabetes, Prilosec for GERD, Lisinopril and Labetalol for hypertension, Cogentin for Tardive Dyskinesia, Lactulose for hyperammonemia, Lithium for schizophrenia, and Trileptal for mania.</p> <p>On 1/14/15 at 11:15 AM, LN #7 confirmed Resident #s 3, 21, 22, 23, 24, and 25, had not received their 7:00 AM medications and stated it was impossible for one nurse to medicate 30 residents all at the same time who had the same administration times for medications.</p> <p>On 1/14/15 at 1:30 PM, the Interim DNS was informed about the delayed medication administration times for the above residents. The</p>	F 332		02/20/2015	

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
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F 332	Continued From page 57 Interim DNS stated it was not possible for one nurse to medicate 30 residents who all had the same scheduled times for medication administration. She stated Cape Elizabeth needed another medication nurse and she would be working on that. On 1/15/16 at 8:15 AM the Administrator was informed about the concern. No further information was provided.	F 332		02/20/2015	
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, it was determined the facility failed to employ a Registered Nurse (RN) as the full time Director of Nursing (DON) or Director of Nursing Services (DNS). This affected 13 of 13 (#s 1-13) sampled residents and all other residents in the facility. Findings included: On 1/12/15 at 12:30 PM, the survey team	F 354	F354 Current Residents: All residents had the potential to be affected Potential New Residents: The facility continues to maintain an Acting DNS and continues to plan to fill a permanent position. New Process: The facility had an Acting DNS at the time of survey and listed the Acting DNS as such on the key personnel sheet, when approached by the surveyor the Acting DNS told the surveyor she was not the Acting DNS. After speaking with the Administrator, she recanted her statement. The facility had never changed her role, she had remained the Acting DNS. The facility continues to maintain an Acting DNS and continues to plan to fill a permanent position. The HR department maintains a file with the start date of the Acting DNS. Monitoring: The Corporate Office will monitor to ensure that the facility maintains a DNS at all times	02/20/2015	

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F 354	<p>Continued From page 58</p> <p>coordinator requested a completed copy of the Facility Key Personnel document from the Administrator, which included a space to identify the DON or DNS. The Administrator provided the survey team with a completed copy of the document with RN #10's name in that space and next to RN #10's name, the form documented, "(acting)."</p> <p>On 1/13/15 at 5:15 PM and 1/14/15 at 4:40 PM, during the end of day conferences with the survey team and the facility administration, the Assistant Director of Nursing Services (ADNS) was present, however, Rn #10, who had been identified as the "acting" DNS was not present.</p> <p>On 1/14/15 at 4:55 PM, the ADNS was interviewed and she confirmed she was a Licensed Practical Nurse (LPN) and not an RN. When asked if she was the acting DNS she stated, "No."</p> <p>On 1/15/15 at 10:40 AM, RN #10 was interviewed. When asked what her title was, she stated, "I'm the MDS Coordinator." When asked if she was the DNS, she stated, "I just found this out last night." When asked if the Administrator had ever informed her she was the DNS prior to the night before, she stated, "No."</p> <p>On 1/15/15 at 12:15 PM, the Administrator was interviewed with the AIT present. When asked if RN #10 was the Acting DNS, she stated, "Yes she is." She said RN #10 was also doing the duties of the MDS Coordinator and had other staff who had assisted her function in the DNS duties. She said she had spoken to the RN about doing the duties of the DNS, but may have been confused.</p>	F 354		02/20/2015	

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F 354	Continued From page 59 On 1/15/15 at 1:40 PM, RN #10 was observed coming out of the Administrator's office and then RN #10 informed the surveyor she was the Acting DNS and had been confused during the previous interview.	F 354		02/20/2015
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 3 of 11 plastic bowls observed and used by residents were free of debris and were able to be sanitized. This had the potential to affect 13 of 13 (#s 1-13) sampled residents and all residents who dined in the facility. This failure created the possibility for food-born illness if bacteria remained on unsanitary surfaces. Findings include: On 1/14/15 at 11:00 AM, with the Certified Dietary Manager (CDM) in attendance, three plastic bowls were observed. One bowl had a two inch band of dried food particles inside the bowl. The CDM stated the particles "may be cereal." The second bowl contained a used plastic snack label inside the bowl. The CDM stated, "It should have	F 371 F371	Current Residents: All residents had the potential to be affected. Potential New Residents: All new residents have the potential to be affected. New Process: Order new Dinex to replace any current damaged or scratched Dinexware. Non-serviceable wears are removed from service each day as dishes are placed in the dishwasher and removed from the dishwasher. Training: The CDM in-serviced staff on proper ware warewashing procedure. Monitoring: CDM will conduct audits to ensure clean dishes 3X/week for one month, then weekly X1month. CDM will conduct audits to ensure any unserviceable wears are removed and discarded 3x/week for one month, then weekly x1 month.	02/20/2015

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F 371	Continued From page 60 been rewashed." The third bowl had what appeared to be a four inch scratch in the top third of the bowl. The CDM stated the microwave heat created glazing and the bowl surface "bubbles up." The CDM took the first two bowls to be rewashed and the third was taken out of service. The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." The 2009 FDA Food Code, Chapter 4, part 4-2, Design and Construction, Subpart 202.11 Cleanability, indicated, "(A) Multituse Food contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, inclusions, pits, and similar imperfections..." On 1/14/15 at 4:40 PM, the Administrator, ADNS, and Clinical Care Coordinator were informed of the issues. No further information was provided by the facility.	F 371		02/20/2015
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372		02/20/2015

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F 372	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the outside trash dumpster area was free from debris. This created the potential for harm should rodents and bugs be attracted to the exposed contents. Findings included: On 1/14/15 between 3:05 PM and 3:40 PM, during the environmental tour with the Maintenance Supervisor present, the two outside trash dumpsters were observed. The following trash debris was littered on the ground to the sides and to the back of the dumpsters: *Two used adult briefs; *17 used exam gloves; *20 plastic cups; *12 plastic spoons; *11 pill cups; *Four empty pill bubble packs; and, *Three soda bottles. The Maintenance Supervisor said, "Most of the garbage isn't in the garbage." On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the trash issue. No further information was provided by the facility.	F 372	F372 New Process: The construction crew has been instructed to use their own dumpsters. Construction is nearly complete. The facility has increased the number of days of the week that the trash is being picked up. Monitoring: The maintenance department is making rounds daily to check the dumpster area to make certain the containers are not overflowing and no trash has been dumped outside the dumpster.	02/20/2015	
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by:	F 468	F468 Current Residents and Potential New Residents: All residents have the potential to be affected by corridors without handrails.	02/20/2015	

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F 468	Continued From page 62 Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 3 of 13 (#s 1, 2, & 10) sampled residents and had the potential to affect any resident who frequented the corridors without handrails. This practice created the potential for residents not to have a handrail for stability when needed. Findings included: On 1/12/15 at 4:35 PM, a four foot section of hand rail between the Boardwalk Dining Room and the DNS office and a four foot section of hand rail between Shower Rooms 1 & 2 were observed to be missing. On 1/14/15 at 3:05 PM, during the environmental tour with the Maintenance Supervisor present, the two areas of missing handrails were observed. He acknowledged the handrails were missing in those areas. On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the handrail issue. No further information was provided by the facility.	F 468	New Process: New handrails have been installed. Monitoring: Maintenance will monitor the entire facility to ensure handrails are in good working order.	02/20/2015	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F514 Current Residents: Resident #2 and 9's Recap/MAR has been updated. Resident #13's chart has been updated to include name/date on all pages. Resident #1's orders have been clarified and updated.	02/20/2015	

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F 514	<p>Continued From page 63</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' medical records were complete. This was true for 4 of 16 (#s 1, 2, 9, & 13) sampled residents. This failure created the potential for medical decisions to be based on incomplete information. Findings included:</p> <p>1. Resident #2 was readmitted to the facility on 3/27/12 with multiple diagnoses including bipolar mental disorder and history of a traumatic brain injury.</p> <p>The resident's January 2015 Physician Order Report and MAR documented, "...KEPPRA 500 MG PO [by mouth] BID [twice a day]...Origin date 8/20/14..." The medication order did not have a diagnosis or an indication for use.</p> <p>The resident's Psychotropic Drug Re-evaluation and Assessment, dated 12/18/14, documented the Keppra, but did not include a diagnosis or indication for its use.</p> <p>On 1/15/15 at 1:10 PM, LN #3 was interviewed regarding the diagnosis for Resident #2's Keppra. The LN said the diagnosis should be on the physician orders and the MAR. When asked to point that out on the resident's documentation, she stated, "Don't see it."</p>	F 514	<p>Potential New Residents: All residents' records will be kept in accordance with acceptable professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.</p> <p>New System: The Change-Over Process has been revised to include night shift nurses, Medical Records staff, and the HIM director. This practice has been implemented to ensure accuracy of records. Medical Records are entering orders in the Continuum System, a computerized EMR system. With Medical Records entering the orders into the system, they are double checking the orders for verification of diagnosis and indication for use for each medication that is ordered. The HIM Director is reviewing the "recaps" for accuracy of orders and diagnosis. The night shift nurses are comparing the MAR and TAR to the "reCap" to ensure accuracy at the end of each month.</p> <p>Training; All nurses have been trained by the ADNS and the HIM Director, on the importance of complete and accurate documentation to include name/date/time on all entries and sheets within the record.</p> <p>Monitoring: Medical Records will audit 20% of charts monthly to ensure for a complete, accurately documented, readily accessible, and systematically organized chart</p>	02/20/2015	

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F 514	<p>Continued From page 64</p> <p>2. Resident #13 was readmitted to the facility on 8/15/14 with multiple diagnoses including multiple sclerosis, contractures of the knee, hip, and ankle, and chronic pain.</p> <p>The resident's Nurse's Notes, dated 10/27/14 through 1/10/15, included 5 of 7 pages without any resident's name documented on them.</p> <p>On 1/15/15 at 5:55 PM, LN #2 was interviewed about the Nurse's Notes provided to surveyors. LN #2 said the Nurse's Notes were documentation for Resident #13. He stated he recognized some of the writing being his and was also familiar with the resident's situation and care.</p> <p>3. Resident #9 was readmitted to the facility on 9/29/14 with multiple diagnoses including traumatic brain injury, schizophrenia and dementia.</p> <p>The resident's Physician Orders, dated 9/29/14, documented the following medications and indication for their use: *Mirtazapine-Schizophrenia; *Trazodone-Insomnia; *Risperdal-Schizophrenia; and, *Zyprexa-Schizophrenia.</p> <p>The resident's January 2015 Physician Order Report and MAR documented the medications above, but did not document the diagnosis or indication for their use.</p> <p>On 1/15/15 at 10:07 AM, LN #3 was interviewed regarding the medications. When shown the order report and MAR and asked where the diagnoses were, she stated, "They should be on there."</p>	F 514	02/20/2015

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F 514	Continued From page 65 4. Resident #1 was readmitted to the facility on 10/26/14 with multiple diagnoses including end stage renal disease and diabetes mellitus Type II. The resident's January 2015 Physician Order Report documented the following orders: -"May use diabetic shoe to left foot only when oob [out of bed], then in heel medix pillow when in bed," dated 10/28/14. -"Heel medix pillows to both feet on at all times," dated 12/22/14. The resident's Skin Problem care plan documented an intervention on 12/22/14 for, "Heel medix boots [at] all times." The resident was observed in his wheelchair with heel pillows on both heels on 1/13/15 at 7:50 AM, 8:17 AM, 9:10 AM, 12:22 PM, and 1:42 PM. On 1/16/15 at 10:35 AM, the DNS was interviewed regarding the Physician Order Report. When asked about the conflicting orders, she pointed to the diabetic shoe order and stated, "This needs to be removed," then she pointed to the heel medix boot order and stated, "as long as this is in place." On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issues. No further information was provided by the facility.	F 514		02/20/2015	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		02/20/2015	

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F 520	<p>Continued From page 66</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Quality Assurance Program, it was determined the facility failed to ensure a designated physician attended the Quality Assurance (QA) meetings. In addition, the facility failed to implement the QA process when environmental quality and sanitary concerns were not addressed and when medication pass logistical plans discussed in the QA meeting were not implemented. These failures had the potential to affect all residents in the facility: *When a physician was unable to provide timely medical guidance or input at the QA meetings;</p>	F 520	<p>F520</p> <p>New Process: The facility has established a Quality Assessment and Assurance Committee consisting of a DNS, the Medical Director, and at least three others. The committee does meet at least quarterly.</p> <p>The facility has implemented: 1. Daily Environmental Rounds by the Housekeeping Supervisor. 2. Quarterly skills checks for the nursing staff. 3. Revised medication process – this was actually developed prior to the survey and had not yet been implemented. 4. All departments had been added to the QA team. 5. The Medical Director had been added to the team and had actually attended his first meeting prior to the survey.</p> <p>The facility has turned over almost the entire top management team, has added an AIT, and is implementing new policies as quickly as possible.</p> <p>The Regional VP of Operations has stepped in as the Administrator to implement new order within the facility.</p> <p>Training: The QA team was trained on the QA process by the Administrator. A new agenda and schedule was set.</p>	02/20/2015	

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F 520	<p>Continued From page 67</p> <p>*When the facility's unsanitary environment could lead to infection and decrease residents' quality of life; and,</p> <p>*When medication pass delays and errors due to logistics could harm residents if medications were given late. Findings included:</p> <p>Intent language for F520 documented the QAA committee is responsible for identifying quality deficiencies and developing and implementing plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans.</p> <p>1. On 1/15/15 at 5:40 PM, the Administrator was interviewed with the AIT present. When asked who attended the QA meetings, she stated, "Not enough people." She stated before she became the Administrator, the Medical Director had not been attending the meetings. The QA minutes sign-in sheet from 4/9/14 to 10/15/14, documented the Medical Director had not attended the meetings.</p> <p>2. The facility was cited at F253 on 10/11/13, during the last recertification survey, and on 1/16/15, when it failed to provide a clean and sanly environment. In addition, F372 was cited on 1/16/15 when the facility failed to secure trash in the outside dumpsters. Refer to F253 and F372 for additional information.</p> <p>On 1/15/15 at 5:40 PM, the Administrator was interviewed with the AIT present and was asked if representatives from housekeeping or maintenance attended the QA meetings. She said neither department were represented, but the plan was for both departments to become part of</p>	F 520	<p>Monitoring :</p> <p>The Administrator will keep an attendance roster with minutes from the quarterly meeting. Theses minutes will be reviewed by the Corporate Compliance Officer.</p>	02/20/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
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F 520	<p>Continued From page 68</p> <p>the QA meeting and process. The QA minutes sign-in sheet from 4/9/14 to 12/18/14, documented neither housekeeping nor maintenance representatives attended the meetings.</p> <p>The Administrator said housekeeping services were contracted and noted she just recently started meeting weekly with the contractor regarding ongoing issues. She also said the QA committee needed to focus on nursing issues before they could, "...tackle the environment."</p> <p>3. The facility was cited at F332 on 1/16/15, when it failed to provide medications in a timely manner. Refer to F332 for additional information.</p> <p>On 1/15/15 at 5:40 PM, the Administrator was interviewed with the AIT present and was asked about how the QA committee had addressed medication pass issues, primarily late medications. She said the QA committee looked at issues regarding nurse staff retention, which can lead to decreased quality of the medication pass process. She also said the committee had looked at the logistics of the medication pass three weeks prior, including how carts were set up, if more nurses could pass medications, and whether additional training and auditing of nurses' skills needed to be completed, but she said the committee had not implemented these plans yet.</p>	F 520		02/20/2015

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual State Licensure and Complaint survey of your facility. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Hukill Neil, RN Brad Perry, LSW The Survey team entered the facility on January 12, 2015 and exited the facility on January 16, 2015.	C 000		02/20/2015
C 118	02.100.03,c,ii Available Services and Charges ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate; This Rule is not met as evidenced by: Refer to F156 as it relates to demand billing, services, and charges.	C 118	C118 Refer to F156	02/20/2015
C 125	02.100.03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 regarding a resident weighed in the hallway.	C 125	C125 Refer to F164	02/20/2015

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judith K. Moore</i>	TITLE Administrator	(X6) DATE 03/25/15
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Bureau of Facility Standards

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C 159	<p>02.100,09 Record of Ptn/Rsdnt Personal Valuables</p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an accounting of personal belongings was completed upon discharge for 1 of 3 (#15) closed records reviewed. Findings included:</p> <p>Resident #15 was admitted to the facility on 6/23/14 with hospice involvement and expired in the facility on 10/15/14.</p> <p>The resident's medical record documented on the Resident Belongings Inventory Form, dated 6/23/14, and signed by a CNA under the admission portion: Glasses, 2-blouses/shirts, 1 pair of pants, 2 sweaters, 1 vest, 2 pairs of pajamas, 11 pairs of socks, 1 pair athletic shoes, 1 small tote, 3 brush/toiletries, 1 baby doll, 1 wheelchair, 1 pair of earrings, 3 stuffed animals, 2 baby blankets, and 1 pair of sunglasses.</p> <p>Resident #15 also had an additional list of inventoried personal belongings, which was not dated or signed. That handwritten list documented: 4 pairs of jeans, 3 sweaters, 5 T-shirts, 2 button up long sleeve shirts, 2 pairs of black jeans, 1 pair of pink flowered jeans, 1 snap up robe, 8</p>	C 159	<p>C159</p> <p>Potential New Residents: All residents have the potential to be affected by the inventory process.</p> <p>New Process: We have re-implemented the inventory process and inventory sheet. A step by step process has been typed up. Social services reviews the inventory on a quarterly basis at the time of the MDS process.</p> <p>Training: The Program Coordinator has educated all CNA staff on the process so as to ensure inventory is completed upon admission and is updated with new inventory accordingly.</p> <p>Monitoring: The Program Coordinator will monitor new admissions for compliance with inventory sheets and inventory check in.</p>	02/20/2015
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Bureau of Facility Standards

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C 159	<p>Continued From page 2</p> <p>sweaters, 1 black coat, 4 long sleeve button ups, 1 baseball cap, and 2 pairs of slacks.</p> <p>The resident's Belongings Inventory Form was blank underneath the discharge portion. Resident #15's medical record did not document the disposition of her personal belongings on the Nursing Progress Notes nor the Social Worker's Notes. The resident's record did not contain a Discharge Summary.</p> <p>On 1/15/15 at 4:45 PM, regarding the disposition of Resident #15's personal belongings, the Medical Records Director stated, "I think the family donated them. I can check with Social Services regarding the belongings."</p> <p>On 1/16/15 at 2:45 PM, the Administrator, DNS, and Clinical Care Coordinator were informed of the issue. The facility provided additional documentation, however this did not resolve the concern.</p>	C 159		02/20/2015
C 325	<p>02.107,08 Food Sanitation</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 regarding bowls not cleaned properly.</p>	C 325	C325 Refer to F371	02/20/2015
C 338	<p>02.108,03,c Sanitary Mantiance of Garbage Containers</p>	C 338		02/20/2015

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C 338	Continued From page 3 c. Garbage containers shall be maintained in a sanitary manner. Sufficient containers shall be afforded to hold all garbage and refuse which accumulates between periods of removal from the premises. Storage areas shall be clean and sanitary. This Rule is not met as evidenced by: Refer to F372 regarding trash around the outside dumpsters.	C 338	C338 Refer to F372	02/20/2015
C 362	02.108,07,a Interior Surfaces Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Please refer to F253 as it relates to a clean and sanitary environment.	C 362	C362 Refer to F253	02/20/2015
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 regarding missing handrails.	C 389	C389 Refer to F468	02/20/2015
C 412	02.120,05,l Cold Water Drinking Fountain Requirements l. A drinking fountain connected to cold running water and which is	C 412	C412 The facility is requesting the waiver be renewed but is asking for a revision of that waiver, the administrator will submit the revision in a separate letter.	02/20/2015

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C 412	Continued From page 4 accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure each nursing unit was equipped with a functioning water fountain. This was true for 3 of 3 nursing units (Cape Hatteras, Cape Elizabeth, and Cape May) inspected. Findings include: On 1/12/15 at 4:50 PM, 3 of 3 nursing units, Cape Hatteras, Cape Elizabeth, and Cape May were observed not to have drinking fountains. On 1/13/14 at 8:40 AM, the Administrator was interviewed and said she would like the drinking fountain waiver renewed. She said residents were provided large water mugs which were filled throughout the day, drinks were provided with the snack carts, and fluids were available on the nursing medication carts.	C 412		02/20/2015
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interviews and review of the facility's Infection Control meetings attendance logs, it was determined the facility failed to ensure the Medical Director, the Pharmacist, the Maintenance Representative, and the Housekeeping Representative attended the	C 664	C664 New Process: All required members will attend the quarterly infection control meeting. The QA team and ICC are all new and have just implemented the new process as of December. Training: The Administrator educated the team on the requirements and the meeting process. Monitoring: Attendance will be kept at each meeting.	02/20/2015

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C 664	Continued From page 6 On 1/14/15 at 4:40 PM, the Administrator, ADNS, and Clinical Care Coordinator were informed of the issue. No other information or documentation was received from the facility.	C 664		02/20/2015
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 regarding the lack of urinary and psychotropic drug use care plans. Please refer to F279 as it relates to initial care plans.	C 779	C779 Refer to F279 Refer to F272	02/20/2015
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F314 as it relates development of a care plan. Refer to F280 as it relates to Care Plans periodically reviewed and revised.	C 781	C781 Refer to F280 Refer to F314	02/20/2015
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:	C 784	C784 Refer to F309	02/20/2015

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C 784	Continued From page 7 This Rule is not met as evidenced by: Refer to F309 regarding the lack of dialysis care, dementia care, and orders for geri sleeves and Ted hose not followed.	C 784		02/20/2015
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F328 as it relates to oxygen use.	C 788	C788 Refer to F328	02/20/2015
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding access to chemicals and falls not prevented.	C 790	C790 Refer to F323	02/20/2015
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315 as it relates to bladder retraining and urinary retention.	C 795	C795 Refer to F315	02/20/2015
C 796	02.200,03,b,xii Rehabilitative Nursing Standards xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in	C 796	C796 Refer to F318	02/20/2015

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C 796	Continued From page 8 promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as related to prevention/decline of ROM.	C 796		02/20/2015
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F332 as it relates to a medication error rate of 43.3%.	C 811	C811 Refer to F332	02/20/2015
C 879	02.203 Resident Records 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as related to complete and accurate medical records.	C 879	C879 Refer to FF514	02/20/2015
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place	C 882	C882 New Process: All death certificates will be signed with a diagnosis and placed in the chart within 7 days of the death of a resident to close the chart. Monitoring: The HIM Director will audit all discharge charts for completeness X3 months.	02/20/2015

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C 882	Continued From page 9 admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to document the final diagnosis or cause of death, the physician's signature, and the disposition of remains for a resident who expired in the facility. This was true for 1 of 3 (#15) sampled residents for review of closed records. Findings included: Resident #15 was admitted to the facility on 6/23/14 with multiple diagnoses including dementia and cerebral vascular accidents. The resident expired in the facility on 10/15/14. The resident's Physician Order, dated 10/15/14 and signed by the Physician on 10/16/14, documented, "...Release body to mortuary of choice..." On 1/15/15 at 4:45 PM, the Medical Records Director (MRD) was interviewed and stated the facility received the resident's Certificate of Death "today at 2:43 [PM]." The Certificate of Death had a date stamp of 1/15/2015 and timed at 2:43 with the cause of death, Physician's electronic signature, funeral facility and the disposition. The MRD stated the facility called the mortuary and faxed the document to them, after the surveyor failed to locate the cause of death, Physician's signature, and the resident's disposition in the closed record.	C 882		02/20/2015

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C 882	Continued From page 10 On 1/16/15 at 2:45 PM, the Administrator, DNS, Clinical Care Coordinator, and LN #2 were informed of the issues. No additional information was provided.	C 882		02/20/2015



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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FILE COPY

March 12, 2015

Judy L. Moore, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Ms. Moore:

On **January 16, 2015**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center of Pocatello. The complaint was investigated in conjunction with the facility's Recertification and State Licensure on-site follow-up survey conducted from January 12 through January 16, 2015.

The following observations were completed:

- All the residents' rooms and bathrooms in the entire facility were observed for cleanliness and odors;
- Resident clothing was observed for tears or damage; and,
- Staff were observed for loud foul language.

The following documents were reviewed:

- The entire medical records of two identified residents;
- Fourteen other residents' records were reviewed for quality of care concerns;
- The facility's grievance file from June 2014 to January 2015;
- Resident Council minutes from September 2014 to December 2014;
- The facility's Incident and Accident reports from July 2014 to January 2015.

The following interviews were completed:

- Sixteen residents were interviewed during the resident group interview regarding quality

- of care and quality of life concerns;
- Four residents were interviewed regarding quality of care and quality of life concerns;
 - The Director of Nursing Services (DNS) and the Administrator were interviewed regarding various quality of care and quality of life concerns;
 - The Housekeeping Supervisor and Maintenance Supervisor were interviewed regarding cleanliness of rooms and bathrooms;
 - Four staff members were interviewed regarding residents' violent behaviors;
 - Five staff members were interviewed regarding loud foul language from staff members; and,
 - A Social Worker was interviewed regarding resident clothing and replacement procedures.

The complaint allegations, findings and conclusions are as follows:

Complaint #6711

ALLEGATION #1:

The complainant stated residents' rooms and bathrooms were not cleaned properly, toilets had brown and black streaks in them and appeared as if they had not been cleaned for an extended period. The complainant also stated the facility smelled of urine.

FINDINGS #1:

During the survey, the following were observed:

- Two residents' toilet bowls were stained brown;
- One resident's bathroom floor was found not cleaned and was sticky;
- One resident's room floor was littered with trash;
- Three residents' room closets were scratched and marred;
- One resident's room had damaged window blinds; and,
- Bowel Movement odors were found in the facility.

Four out of 16 residents in the group interviewed said their toilets were not cleaned properly.

Two out of 16 residents in the group interviewed said their room floors were not cleaned properly.

The Housekeeping Supervisor was interviewed regarding the cleanliness of rooms and bathrooms as well as the odors and he said there were issues.

The Maintenance Supervisor was interviewed regarding cleanliness of toilets and he stated there

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were issues with them.

Based on observations and staff interviews, the allegation was substantiated, and the facility was cited at F253. Refer to F253 for additional information.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident's medication was decreased and the reduction did not address his or her violent behaviors, including hitting staff and other residents monthly. As an example, the identified resident hit another identified resident, without causing injury.

FINDINGS #2:

The identified resident was observed for violent behaviors throughout the survey, and none were observed.

The entire medical record of the identified resident, from January 2014 to January 2015, was reviewed, and only one incident was found where the resident acted violently towards another resident. The record documented the resident's medication was not decreased prior to the incident. In addition, the record documented the resident had not experienced any other violent behaviors since the incident.

Seven other residents' records were reviewed for violent behaviors related to decreased medications, and none were found to be violent.

One licensed nurse was interviewed regarding the identified resident's behaviors, and she said the behaviors had not increased and the resident had not hit anyone since the original incident.

Three Certified Nurse Aides (CNAs) were interviewed regarding how to react to violent residents, and they each said they would separate them or get in between them and get help immediately.

Based on the observations, records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated most of the residents in the facility had torn or damaged clothing and facility staff would not replace the damaged clothing.

FINDINGS #3:

Throughout the entire survey, resident's clothes were observed and no concerns were found.

Four residents were interviewed, and they did not voice concerns regarding torn or damaged clothing.

Sixteen residents in the group interview were interviewed and said there were no issues with torn or damaged clothing.

A Social Worker was interviewed and said if a resident has torn or damaged clothing the facility will try to find replacement clothing, either through donated clothing or they would buy clothing at a local retail chain store for the residents.

Based on observations, residents' interviews and a staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated a facility's associate used loud foul language directed to other staff members in front of residents.

FINDINGS #4:

During the survey, staff members were observed for loud foul language, and there were no concerns identified.

Four residents were interviewed, and two of the residents said staff members had not used loud foul language, and two others said they had no concerns with staff behaviors.

Sixteen residents in the group interview said staff were respectful and appropriate around them.

Five staff members were interviewed and said they had never heard other staff using loud foul language near or around the residents.

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Based on the residents' interviews and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the facility has been remodeling and there is asbestos in the building. The facility is covering the asbestos up instead of removing it.

FINDINGS #5:

According to the facility's 2014 Occupational Safety Administration and Health Administration (OSHA) report, the facility "submitted documentation to (Occupational Safety Administration and Health Administration) to verify appropriate and timely testing for asbestos, the knowledge of limited locations of asbestos-containing materials (ACM's) not within safe levels, and precautions taken to avoid working in any area that could expose employees or residents to asbestos dangers."

In 2014, the Environmental Risk Management Agency (ERMA) surveyed the areas at the hospital that were under consideration to be remodeled. The ERMA "reported that no suspect ACMs were in the kitchen area of the facility, which was the area to be remodeled."

The ERMA asbestos survey report documented "had shown that some areas of corridor ceiling did contain ACMs." The facility "decided to defer any work in the corridor until a later date in the project as this corridor currently serves as the main path of egress for a large portion of the facility." Throughout this process (the facility) did not disturb any ACMs. When the time comes to do any work in the suspect corridor, (the facility) will employ a licensed asbestos abatement contractor to remove all ACMs."

Based on Administrator and CEO interviews and documentation review, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated dressing changes are being charted but are not actually happening. "The wound is now scabbed over but the nurse is still documenting regular dressing (changes)."

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FINDINGS #6:

The nurses' notes, physician's orders, and treatment sheets for the identified resident were reviewed and documented the resident sustained an injury on her right leg below her knee and a dressing was applied and changed.

The resident was observed from January 12 to January 16, 2015, multiple times to be wearing shorts and was not observed to have a dressing on either of her lower extremities.

The resident's Power of Attorney (POA) was interviewed and did not verbalize concerns related to the care and treatment of the resident, to include dressings not being changed as ordered. Additionally, the POA stated the resident had not verbalized concerns related to a dressing not being changed.

A resident was observed during survey to receive dressing changes as ordered, and the nurse was observed to document her initials after the dressing change was completed.

Based on staff and family interviews and records reviewed, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj