



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
Boise, ID 83720-0009
PHONE 208-334-6626
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FILE COPY

February 9, 2015

Justin M. Polson, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Polson:

On **January 23, 2015**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 8, 2014**. However, based on our on-site follow-up revisit conducted **January 23, 2015**, we found that your facility is not in substantial compliance with the following participation requirements:

F314 -- S/S: G -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores
F323 -- S/S: D -- 42 CFR §483.25(h) -- Free of Accident Hazards/Supervision/Devices
F514 -- S/S: D -- 42 CFR §483.75(l)(1) -- Resident Records-Complete/Accurate/Accessible

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. **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 Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B listing deficiencies that have been

corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 23, 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*.

As noted in the letter of **November 19, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **November 5, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **May 5, 2015**, if substantial compliance is not achieved by that time. CMS letters that were sent to your facility on November 26, 2014, and December 15, 2014, outlined specific remedies imposed.

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, CMS will provide you with a separate formal notification of that determination.

Justin M. Polson, Administrator
February 9, 2015
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If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

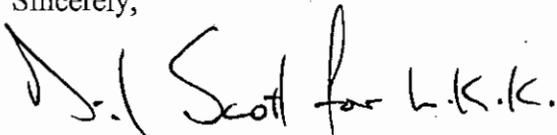
- BFS Letters (06/30/11)

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

This request must be received by **February 23, 2015**. If your request for informal dispute resolution is received after **February 23, 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 on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

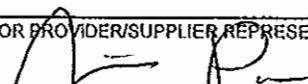
PRINTED: 02/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/23/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3650 WEST AMERICANA TERRACE BOISE, ID 83708
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification follow-up survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Susan Gollobit, RN</p> <p>The survey team entered the facility on 1/22/15 and exited on 1/23/15.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed RD = Registered Dietician SLP = Speech Language Pathologist TAR = Treatment Administration Record</p>	{F 000}	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".</p>	
{F 314} SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</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</p>	{F 314}	<p>F 314</p> <p>#1 Resident #16 and #17 have discharged from the facility.</p>	2/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/18/15
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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 314}	<p>Continued From page 1 services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record documentation, and observations, the facility failed to ensure that a resident who entered the facility with a pressure ulcer did not acquire one. This was true for 2 of 6 (#s 16 & 17) sampled residents. Resident #17 was harmed when, after episodes of bowel incontinence, her skin became macerated and a sore opened on the coccyx resulting in a Stage III pressure ulcer with full thickness tissue loss. Resident #16 was harmed when at least two different open areas developed Stage II pressure sores, one on the gluteal fold and one on the coccyx. Findings include:</p> <p>Interpretive guidance at F314 states: The comprehensive assessment should address those factors that have been identified as having an impact on the development, treatment and/or healing of pressure ulcers, including, at a minimum: risk factors, pressure points, under-nutrition and hydration deficits, and moisture and the impact of moisture on skin. Examples of these risk factors include, but are not limited to:</p> <ul style="list-style-type: none"> -Impaired/decreased mobility and decreased functional ability; -Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus; -Drugs such as steroids that may affect wound healing; -Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency; 	{F 314}	<p>Upon discharge from the facility resident #17's wound had resolved.</p> <p>A root cause analysis revealed appropriate assessment, nursing diagnosis, planning, implementation and evaluation were not conducted in regards to skin integrity.</p> <p>#2 All current and future residents have the potential to be affected.</p> <p>The Medical Director approved new standing orders for the use of Barrier Cream prn to prevent skin breakdown from bowel or bladder incontinence. Orders were received and implemented.</p> <p>The DON conducted a training session on February 10, 2015 regarding the prevention of pressure ulcers, identifying, risk factors for skin concerns, updating care plans, and interdisciplinary team communication.</p>		

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{F 314}	<p>Continued From page 2</p> <ul style="list-style-type: none"> •Resident refusal of some aspects of care and treatment; •Cognitive Impairment; •Exposure of skin to urinary and fecal incontinence; •Under nutrition, malnutrition, and hydration deficits; and •A healed ulcer. The history of a healed pressure ulcer and its stage [if known] is important, since areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown. <p>Moisture and Its Impact Both urine and feces contain substances that may irritate the epidermis and may make the skin more susceptible to breakdown. Some studies have found that fecal incontinence may pose a greater threat to skin integrity, most likely due to bile acids and enzymes in the feces. Irritation or maceration resulting from prolonged exposure to urine and feces may hasten skin breakdown, and moisture may make skin more susceptible to damage from friction and shear during repositioning. It may be difficult to differentiate dermatitis related to incontinence from partial thickness skin loss (pressure ulcer). This differentiation should be based on the clinical evidence and review of presenting risk factors. A Stage I pressure ulcer usually presents as a localized area of erythema or skin discoloration, while perineal dermatitis may appear as a more diffuse area of erythema or discoloration where the urine or stool has come into contact with the skin. The dermatitis may occur in the area where the incontinence brief or underpad has been used. Also, the dermatitis/rash more typically presents as intense erythema, scaling, itching, papules, weeping and eruptions.</p>	{F 314}	<p>Current residents have been reassessed. The Braden Risk Assessment tool was completed as well as a full Head to Toe Skin Assessment.</p> <p>The interdisciplinary team has been informed of the Braden Scores as well as any identified skin concerns.</p> <p>Care plans have been reviewed and revised to address risk areas as well as identified skin concerns.</p> <p>Upon admission, the facility will conduct a Braden Scale assessment, and a head-to-toe skin assessment. The interdisciplinary team to include, but not limited to, the provider, the DON, and the Dietician will be notified of any moderate or high risk residents identified as well as any skin concerns.</p> <p>All residents will have a head-to-toe weekly assessment. Provider and Interdisciplinary team will be notified of concerns regarding skin</p>		

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{F 314}	Continued From page 3 1. Resident #17 was admitted to the facility on 12/19/14 for rehabilitation of a joint replacement and unspecified essential hypertension. The 12/19/14 Nursing Admission assessment documented the resident was continent of bowel and bladder and no skin issues were identified. The 12/27/14 Admission MDS documented the resident: - Was cognitively intact with a BIMS of 15, - Required extensive assistance with bed mobility, transfers, ambulation, dressing, toilet use and bathing, - Was continent of bowel and bladder, - Had a surgical incision for skin issues, - Had a pressure reducing device for her chair but no pressure relieving devices for her bed. The resident was not on a turning and positioning plan and did not receive any special nutritional supplements for skin issues. - Did not have pressure sores or MASD. (Moisture Associated Skin Damage) The resident's physician orders included the following: 12/19/14 - Client may have pressure relieving cushion in wheelchair. 12/19/14 - Weekly skin check (fill out skin assessment) at bedtime every Friday. 1/2/15 - May have pressure relieving mattress on bed. 1/3/15 - Imodium A-D Tablet 2 mg (Loperamide HCl) Give 2 mg by mouth every 6 hours as needed for diarrhea. 1/3/15 - Cleanse wound to coccyx with wound cleanser, pat dry. Apply Silvakollagen gel to wound bed then cover with bordered gauze.	{F 314}	integrity. Care plans will be updated, as needed. #3 The Skin Policy and Procedure has been reviewed and revised to outline the nurse responsibilities upon admission and throughout the resident's stay. This includes the completion of weekly Braden scores x4 weeks and prn and a head to toe assessment every week, ongoing. The Pressure Ulcer Prevention and Treatment Pathway decision tree will guide staff through the process. Education related the revised policy as well as competency testing is scheduled for February 21, 2015. The IDT will continue to meet every week to discuss residents with nutrition/skin concerns, including a review of the Braden Assessment and Head to Toe Assessment findings. Routine Nursing in-services will be conducted monthly for three months and prn regarding		

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{F 314}	<p>Continued From page 4</p> <p>1/10/15 - Beneprotein or equivalent two times a day for wound/nutrition 1 scoop mixed with meals.</p> <p>1/16/15 - Juven or equivalent two times a day for supplement mix with orange juice.</p> <p>1/20/15 - Diet changed to High Calorie/Fortified diet mechanical soft texture.</p> <p>1/22/15 - Mighty shake three times a day for nutrition 4 oz.</p> <p>Nursing and other discipline care provided to the resident was documented in an electronic medical record (EMR): The program allowed for changes to be made to a care plan. The electronic record program would keep the date the original documentation was made, but not put the date the changes were made. This process made it difficult to determine when care plan changes were made because the dates on the review document provided to surveyors were the dates the original plan was developed. The surveyor had to request a historical review of each focus, goal, and intervention to determine when the change actually occurred.</p> <p>The resident's skin care plan, with dates of initiation documented: Focus: "(Resident Name) has a pressure ulcer development r/t (related to) mobility limitations and bowel incontinence." 12/19/14 NOTE: A historical review of the plan documented the modification actually took place on 1/14/15. Goals: "She will have Intact skin, free of redness, blisters or discoloration by/through review date." 12/19/14, and "(Resident Name) pressure ulcer will show signs of healing and remain free from infection by/through review date." 1/14/15 Interventions/Tasks: - "Administer beneprotein as ordered. 1/22/15</p>	{F 314}	<p>nursing process for skin integrity to include; the assessment, nursing diagnosis, planning, intervention and evaluation of skin integrity.</p> <p>A new skin care protocol is being developed in conjunction with DermaRite (the provider of the facility's wound care products). This program will outline consistent treatment protocols for nurses to follow. If/when the facility has an open wound, the new protocol will be implemented. An algorithm regarding wound care intervention decision making has been formulated, implemented, and supplied to the nursing staff.</p> <p>#4</p> <p>In room care plan checks have been completed to verify necessary preventative measures are in place.</p> <p>DON or designee will conduct a full house audit to identify residents with moderate to high risk Braden scores and conduct a care plan review each week</p>		

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{F 314}	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Administer Juven as ordered. 1/22/15 - Administer medications as ordered... 1/14/15 - Administer treatments as ordered and monitor for effectiveness. - (Resident Name) requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. 1/14/15 - Follow therapy recommendations regarding pressure relieving cushion in wheel chair. 12/19/14 - May provide patient with a pressure relieving air mattress. 1/6/15 - Monitor dressing to ensure it is intact and adhering. Report lose(slc) dressing to Treatment nurse. 1/14/15 - Monitor nutritional status. Serve diet as ordered, monitor intake and record. 12/19/14 - Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length x width x depth) stage. 12/19/14 - Refer to wound clinic for wound care management." 1/22/15 <p>A Braden scale risk assessment for pressure ulcers, completed by the facility on 12/19/14 documented the resident was not at risk for skin break down. No other risk assessments were completed for this resident.</p> <p>The EMR documented the Nutritional Evaluation was started on 12/26/14 and signed by the Dietitian on 1/23/15. It is unclear when the dietitian actually interacted with the resident to do the evaluation. The dietitian did not address the skin and bowel issues the resident had during this time frame. {Note: The resident had bypass surgery in the 1980's that contributed to periods of chronic diarrhea.} The evaluation documented,</p>	{F 314}	<p>for 2 months. Audit will ensure resolution of care plan lines and orders. Further, the audit will ensure proper interventions are in place to meet client condition. Weekly nutrition at risk meetings with the interdisciplinary team, which includes DON and RD, will review Braden Scales and any new identified skin issues. Wound specific care plans will be reviewed for accuracy and proper EMR dates reflecting addition of all new interventions.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>CQI meeting will be held monthly. The skin program will be reviewed.</p> <p>A compliance Officer representing the Board will visit the facility Q month to perform compliance reviews.</p>	

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{F 314}	Continued From page 6 "...Observed the resident with brunch. Pushes food around plate and takes few bites. Spoke with sister upon admit re: poor intakes with the initiated (sic) of the mechanically altered diet to aide in manipulation as resident appeared tired. Observed resident also at that time with poor appearance and did not respond much to questions. Resident today requests foods 'chopped' explained chopped vs mechanical soft and resident agreeable to mechanical soft textures. Resident did not indicate today the hx (history) of wt (weight) loss and unsure of weight recently but states would like to decrease wt...Discusses appropriateness of wt loss and agrees to supplement and MVI {multi-vitamin}...." Nurse's notes (NN), skin/wound notes (WS), dietary notes (DN), skin assessment (SA) and Wound/Skin Healing Assessments (WSHA)documented the following: 12/24/14 - 1:28 PM, NN, "... Patient noted to have loose stools this morning with an incontinent episode. Peri area cleaned and protection cream applied to peri area and gluteal fold..." 12/30/14 - 4:24 AM, NN, "...Patient did not have diarrhea this shift..." 1/3/15 - 6:00 PM, WS, "Type of wound: Stage 3 ulcer-full thickness. Location of wound: Coccyx area. Size of wound: 5 cm L X 0.4 cm w x 0.2 cm depth. Type of drainage: Scant amount of serosanguineous, no odor, wound bed with red granulation, peri-wound pinkish-red, wound edges defined, surrounding tissues firm, pain to area when touched." 1/3/15 - 6:16 PM, NN, "Late entry - Patient noted with full thickness stage 3 ulcer to coccyx at 0700 {7:00 AM} this morning after 2nd episode of large looses (sic) stool in 4 hours. Wound note documented. Patient had gastric bypass in the	{F 314}	A Nurse Consultant will assist with care plan reviews as requested. #5 Completion Date: 2/23/15		

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{F 314}	Continued From page 7 1980's..., has had monthly episodes of loose stools that can last as long as a week... Patient now has airbed, wound care orders, pressure relieving cushion and has already been started on nutritional shakes for supplement. Patient educated on above but barriers are cognition, incontinence and compliance with repositioning... 1/4/15 - 8:21 AM eMar, "Immodium {sis} A-D Tablet 2 MG, Give 2 mg by mouth every 6 hours as needed for diarrhea...Patient requested for diarrhea." 1/5/15 - 3:55 PM, NN, "... Bandage changed to coccyx wound as ordered..." 1/7/15 - 3:39 AM, NN, "... Patient has stage III wound on her coccyx that is being addressed and have been continuing to monitor and change dressing according to care plan and order. She doesn't appear to be infected, no redness and warm to the touch..." 1/7/15 - 11:55 AM, NN, "Monitor open abrasion to gluteal fold. Apply skin protection cream daily two times a day for skin care Wound orders changed." 1/8/15 - 3:56 AM, NN, " Patient is alert and oriented x4 with some mild confusion...Patient's dressing to coccyx was changed 1/7/15. Patient has been very pleasant and cooperative well with all her care and treatments. Patient is a 2 {person} extensive assist and uses a wheelchair..." 1/10/15 - 6:18 PM, NN, "Dressing to patient's gluteal folds have been changed. Stage III, serosanguinous drainage. No signs of infection." 1/16/15 - 10:45 PM, SA, "Other: Intergluteal Cleft with open area approximately 3 cm x 0.25 cm, wound bed with yellow slough, wound edges red, moderate amount yellow/pink drainage noted, no odor, tender to touch red area approximately 3 cm x 1 cm in size, non-blanchable, not open.	{F 314}			

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{F 314}	<p>Continued From page 8</p> <p>Right buttock: red area approximately 3cm x 1cm in size, non-blanchable not open. Right Buttock: red area measuring approximately 3.5cm x 0.5cm in size, not open, no s/s infection. Right Buttock: Red area noted to be approximately 10cm in length, appears to be an old blister, not open, no s/s infection." {Note: The residents medical record lacked any further information about what the facility did with all of the areas.}</p> <p>1/20/15 1:53 PM, eMAR note, "Imodium A-D Tablet 2 mg, Give 4 mg by mouth every 6 hours as needed for diarrhea, Patient having multiple episodes of loose stools."</p> <p>1/23/15 - 7:11 AM, WSHA, "Wound/Skin healing record - Site: Coccyx; Type: Pressure; Length 2.5 cm x Width 0.2 cm x Depth 0.2 cm; Stage III; 1a. Type of wound - 4. Pressure Ulcer; Description of wound bed - 2b. Granulation tissue: pink or red tissue w/ shiny, moist, granular appearance, no exudate; and Surrounding Tissue/wound edges - rolled edges and not having pain."</p> <p>The resident, who was visiting with a family member at the time, was observed in bed on 1/23/15 at 11:15 AM. The resident's bed was equipped with an air mattress.</p> <p>The Administrator and DON were interviewed on 1/23/15 at 3:20 PM regarding the resident's pressure ulcer. When asked why the care plan was not updated and interventions put in place sooner than they were, the DON stated that changes were made once the wound opened up. The wound opened up on 1/3/15, but no changes were made to the care plan until 1/14/15, (11 days after the pressure ulcer developed) and the resident had frequent diarrhea, but only received Imodium on 1/4/15 and 1/20/15.</p>	{F 314}			

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{F 314}	<p>Continued From page 9</p> <p>On 1/26/15 the facility provided additional information from a physician, who documented the wound was due to "incontinence dermatitis of sacral/gluteal fold. Area with gluteal cleft skin tear. This is not consistent with a pressure ulcer." The area on the gluteal cleft was identified on 1/16/15. The physician did not address the area on the coccyx. The physician did not address the resident's bowel incontinence, which caused the dermatitis that lead to the resident having fragile skin and eventual skin breakdown.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Assess the resident in a timely manner when skin issues started to appear, - Develop a care plan to prevent skin breakdown in a timely manner. - Provide antidiarrheal medication more often than two times in a 20 day period. - Clearly document skin issues eg. location, etiology, preventions and treatments. <p>2. Resident #16 was admitted to the facility 12/18/14 with diagnoses of rehabilitation for acute myocardial infarction, atrial fibrillation and sleep apnea.</p> <p>The 12/18/14 Nursing Admission assessment documented the resident was continent of bowel and bladder and the skin issues identified were mostly bruising and abrasions. No open areas were identified for the resident's gluteal region.</p> <p>The 12/24/14 Admission MDS documented the resident:</p> <ul style="list-style-type: none"> -Was cognitively intact with a BIMS of 15, -Required limited assistance with bed mobility, transfers, ambulation, dressing, toilet use, personal hygiene and bathing, 	{F 314}			

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{F 314}	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Was continent of bowel and bladder, -Received a diuretic. -Did not have pressure sore or MASD. <p>The resident's physician orders included the following:</p> <p>12/18/14 - "Client may have pressure relieving cushion in wheelchair.</p> <p>12/29/14 - Monitor opened weeping blisters to right last two toes. Cleanse daily with wound cleanser, apply ABD pad for absorption and wrap with coban. Monitor for s/sx of infection, one time a day for wound care.</p> <p>1/7/15 - Patient will have pressure relieving air mattress for skin integrity.</p> <p>1/14/15 - Cleanse wound to right inner gluteal fold with NS and apply Polymen Silver foam dressing. Secure with tape. Monitor for s/sx of infection one time a day for wound care."</p> <p>The resident's care plan documented: Focus: "(Residents Name) has potential for pressure ulcer development r/t limited mobility.</p> <p>12/18/14 Goals: He will have intact skin, free of redness, blisters or discoloration by/through review date. 12/18/14</p> <p>Interventions/tasks:</p> <ul style="list-style-type: none"> - Follow therapy recommendations regarding pressure relieving cushion in wheelchair. 12/18/14 - He needs encouragement with use of bed rails for resident to assist with turning. 12/18/14 - Monitor nutritional status. Serve diet as ordered, monitor intake and record. 12/18/14 - Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length x width x depth), stage. 12/18/14 	{F 314}			

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{F 314}	<p>Continued From page 11</p> <ul style="list-style-type: none"> - The resident requires pressure relieving/reducing air mattress on bed. 1/7/15 - Treat pain as per orders to ensure his comfort. 12/18/14 - Turn and reposition Q2H and PRN. 1/22/15" <p>A Braden scale risk assessment for pressure ulcers, completed by the facility on 12/18/14 documented the resident was not at risk for skin break down. No other risk assessments were completed for this resident.</p> <p>Nurse's notes (NN), skin assessments (SA) and Wound/skin Healing Assessment (WSHA) documented the following:</p> <p>12/18/14 - 5:18 PM, NN, "...patient will need air mattress to decrease body stress... Patient did not allow a skin check to be performed. Patient requested a bath tomorrow a.m. and skin check will be performed at that time..."</p> <p>12/21/14 - 2:16 PM, NN, "...Patient states that diuretic is working as he is urinating all of the time..."</p> <p>12/28/14 - 1:07 PM, NN, "...Patient stating he hasn't been sleeping well due to air mattress being too uncomfortable and wearing C-pap on and off at HS due to the pressure being too strong and feeling like he cant [sic] catch his breath...Patient offered to try a regular mattress to see if may be more comfortable...Leg elevated in recliner chair and while in bed..."</p> <p>1/1/15 - 4:54 PM, NN, "...NOC [Night shift] LPN reported that the resident spent night in recliner... Continent of B & B [Bowel and Bladder]..."</p> <p>1/1/15 - 5:47 PM, SA, "Site: Other, Description: At coccyx area, blanchable redness. Area is approximately 3 cm from center on each side and 10 m long covering tip of coccyx down through</p>	{F 314}			

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{F 314}	Continued From page 12 folds in buttocks. Skin intact no other skin issues at this time." 1/6/15 - 1:56 AM, NN, "...Skin warm and dry....Patient asleep in chair..." 1/8/15 - 6:38 PM, SA, " Site Coccyx, Description: Area present measures at 2.5 cm x 7.5 cm long with open area mid coccyx that measures at 1.5 cm long and .5 cm width, area clean and barrier cream applied. No further issues noted after skin assessment completed." 1/13/15 - 5:32 PM, NN, "Patient Alert and Oriented X 4. Small 0.3 cm x 0.3 cm open wound noted to inside of right gluteal fold. Barrier cream applied..." 1/13/15 - 5:48 PM, NN, "Site: other, Description: Open wound to inside of right gluteal fold measuring at 0.3 cm x 0.3 cm. Will notify MD for TX orders." 1/14/15 11:20 PM, NN, "...Patient is currently sleeping in his recliner with his legs elevated..." 1/22/15 - 2:41 AM, NN, "...All open skin assessed, no signs of skin issues observed..." 1/22/15 - 5:02 PM, AS, "Site: Coccyx, Description: Open area to mid coccyx measures at 1.8 cm x .8 cm with redness surrounding wound bases measures 2.5 cm x 2 cm width." 1/23/15 - 4:50 AM, NN, "...Still sleeping in his recliner for most of the night..." 1/23/15 - 7:06 AM, WSHA, "Wound/Skin healing record - Site: Coccyx; Type: Depression with exudate; Length 0.4 cm x Width 0.2 cm x Depth 0.1 cm; Stage: Blank; Type of wound: other 'etiology unknown, wound consult arranged with wound clinic.'; Description of wound bed: epithelial tissue: new skin growing in superficial ulcer. It is pink and shiny; Exudate: Serosanguineous; Exudate amount: Small; Surrounding skin Color: pink; Surrounding tissue/wound edges: Maceration; and Pain: none"	{F 314}			

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{F 314}	<p>Continued From page 13</p> <p>On 1/22/15 at 11:35 AM and 1/23/15 at 8:35 AM the resident was observed sitting in his recliner. The recliner had a pressure relieving device in it and the resident's bed did have an air mattress on it.</p> <p>The DON was interviewed on 1/23/15 at 3:30 PM about the resident's skin issues. According to the record, the resident started to have skin issues on 1/1/15, but the care plan was not updated or changed to prevent the skin from eventually breaking down. The DON stated the care plan was changed when the area opened up, however the only intervention changes were the addition of an air mattress on 1/7/15 and a turning program on 1/22/15.</p> <p>On 1/26/15 the facility provided further information from the Nurse Practitioner (NP) who evaluated the open area. The NP documented: "Wound to gluteal region consistent with maceration d/t [due to] moist environment. Wound not consistent with pressure. Care plan is reflective of potential for pressure ulcer, and is consistent with skin condition..."</p> <p>NOTE: The care plan provided to surveyors on 1/23/15 did not identify "maceration due to a moist environment" as the reason for pressure ulcer development. Further, it was not clear if the NP was referring to the open are on the gluteal fold or the wound on the coccyx.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Assess the resident for moisture associated skin breakdown, - Develop care plan interventions timely to prevent skin breakdown, 	{F 314}			

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{F 314}	Continued From page 14 - Identify risks of the resident sitting in the recliner long periods of time, - Clearly identify where resident skin issues were located, how many there were, and descriptions of the sores. - Clearly document preventative and ongoing treatments to the resident skin.	{F 314}			
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure 6 of 6 residents (#14, 15, 16, 17, 18 & 19) were assessed for safety with the use of side rails. The deficient practice had the potential to cause more than minimal harm when all 6 of the residents used side rails and the assessment did not identify each of the residents to be safe with the use of side rails. Findings included: 1. Resident #14 was admitted to the facility on 12/15/14 with diagnoses which included other specified rehabilitation procedure and aftercare involving internal fixation device. The resident's recapitulation physician orders documented bilateral quarter side rails to assist	{F 323}	<u>F 323</u> #1 Resident #14, #16, #17 and #19 have discharged from the facility. The root cause analysis revealed that the previous side rail safety assessment did not indicate the residents' ability to use the side rails safely. Nursing side rail safety assessment has been updated to reflect the residents' ability to safely use the side rails. Resident #15 and #18 have had a comprehensive side rail safety assessment completed on 1/23/15 prior to the surveyors exiting the facility. #2 All residents using side rails have the potential to be affected. All current residents	2/23/15	

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{F 323}	<p>Continued From page 15 with bed mobility. The start date was 12/15/14.</p> <p>The resident's Admit/Readmission Assessment, dated 12/15/14, documented the resident used bilateral quarter side rails and were "Indicated for safety," "Indicated to promote independence with bed mobility" and a "Consent received for bilateral side rails." The form did not document the side rails had been assessed to be safe for the resident to use.</p> <p>On 1/23/15 at 09:55 AM, the resident was observed in bed asleep. The resident's bilateral quarter side rails were up.</p> <p>On 1/23/15 at 11:15 AM, the DON was asked for the resident's side rail assessment which documented the side rails were safe for the resident to use. The DON stated the assessment was documented on the admit/readmission assessment. The DON reviewed the resident assessment and read the section that documented side rail. The DON read side rails "Indicated for safety," and stated, "That is not the language he was suppose to use." The DON stated the facility had redone the whole assessment to include the side rails were safe for use by the resident and verified the assessment did not document this statement.</p> <p>On 1/23/15 at 1:35 PM, a new assessment was documnted in the resident's chart and the DON was asked where it had come from. The DON stated the facility had gone back to the old side rail assessment which documented the resident was safe to use the side rails.</p> <p>2. Resident #18 was admitted to the facility on 1/5/15 with diagnoses which included aftercare</p>	{F 323}	<p>have had their side rail safety assessment re-conducted using the updated side rail safety assessment to ensure the residents' ability to safely use their side rails. The new admission nursing checklist has been update to remind the admitting nurse to complete the side rail safety assessment.</p> <p>#3 The Bed Safety Policy and Procedure was reviewed and revised.</p> <p>The side rail safety assessment will systematically be conducted upon admission and before the implementation of side rail use to ensure the residents' ability to use the side rails safely.</p> <p>Nursing staff were educated on performing a side rail safety assessment on patients to verify the residents' ability to use the side rails safely.</p> <p>#4 In room care plan checks have been completed to verify side rails are consistent with assessments and orders.</p>	

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{F 323}	<p>Continued From page 16</p> <p>healing for traumatic bone fracture and rehabilitation.</p> <p>The resident's recapitulation physician orders documented bilateral quarter side rails to assist with bed mobility. The start date was 1/5/15.</p> <p>The resident's Admit/Readmission Assessment, dated 1/5/15, documented the resident used bilateral quarter side rails and were "Indicated for safety," "Indicated to promote Independence with bed mobility" and a "Consent received for bilateral side rails." The form did not document the side rails had been assessed to be safe for the resident to use.</p> <p>3. Resident #19 was admitted to the facility on 12/24/14 with diagnoses that included rehabilitation and morbid obesity.</p> <p>The resident's recapitulation physician orders documented bilateral quarter side rails to assist with bed mobility. The start date was 12/24/14.</p> <p>The resident's Admit/Readmission Assessment, dated 12/24/14 documented the resident used bilateral quarter side rails and were "Indicated to promote independence with bed mobility" and a "Consent received for bilateral side rails." The form did not document the side rails had been assessed to be safe for the resident to use.</p> <p>4. Resident #15 was admitted on 12/3/14 to the facility for rehabilitation from pneumonia and paralysis agitans.</p> <p>The resident was using bilateral quarter side rails on his bed. The facility had failed to assess the</p>	{F 323}	<p>DON or designee will conduct audits on all new admissions for 2 months to ensure the side rail safety assessment has been completed and the ability of the resident to use the side rail safely is indicated.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A Compliance Officer representing the Board will visit the facility Q month to complete a compliance review.</p> <p>Nurse Consultant will assist with auditing systems as requested.</p> <p>#5 Date of completion: 2/23/15</p>		

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{F 323}	Continued From page 17 resident to be safe to use the side rails until it was brought to the attention of the DON on 1/23/15 at 11:00 a.m. An assessment was completed on 1/23/15 at 12:31 p.m. 5. Resident #16 was admitted to the facility 12/18/14 with diagnoses of rehab for acute myocardial infarction, atrial fibrillation and sleep apnea. The resident was using bilateral quarter side rails on his bed. The facility had failed to assess the resident to be safe to use the side rails until it was brought to the attention of the DON on 1/23/15 at 11:00 a.m. An assessment was completed on 1/23/15. 6. Resident #17 was admitted to the facility on 12/19/14 for rehabilitation of a joint replacement and unspecified essential hypertension. The resident was using bilateral quarter side rails on his bed. The facility had failed to assess the resident to be safe to use the side rails until it was brought to the attention of the DON on 1/23/15 at 11:00 a.m.. An assessment was completed on 1/23/15 at 11:38 p.m.	{F 323}			
F 514 SS=D	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	F 514	<u>F 514</u> #1 Resident #14 and #17 have discharged from the facility. The root cause analysis reveals that systems were not	2/23/15	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2015
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 18</p> <p>Information to identify the resident; a record of the 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 record review and staff and resident interview it was determined the facility failed to ensure records were complete and accurate related to weight loss for 1 of 6 residents (#14) whose records were reviewed. Lack of documented follow up in the resident's record after an 8.2 pound weight loss had the potential for the resident to not receive needed services. Additionally, the facility's electronic medical record (EMR) did not document the date Resident #17's care plans were modified, or when a nutritional evaluation was provided to the resident during the development of multiple pressure ulcers. Findings include:</p> <p>1. Resident #14 was admitted to the facility on 12/15/14 with diagnoses which included rehabilitation and aftercare involving internal fixation device.</p> <p>The facility's Friday Weight Day form, dated 1/9/15, documented the resident had an 8.2 pound weight loss from the previous week (1/2/15). The form documented the resident's room number as 119. "119- started a diuretic on Tuesday" was written on the bottom left corner of the form. The form included staff initials for that date by the Nurse Practitioner (NP), dietary manager and two nursing staff.</p>	F 514	<p>comprehensive enough to ensure proper Provider, DON, and Dietician notification. The EMR does not reflect changes to care plan on "current" CP view. The data collection tool "Friday Weight Day Form" included all residents and weight data for provider convenience. Resident specific notification and follow up was not documented in individual records.</p> <p>#2 All residents in the facility have the potential to be affected if the facility does not maintain complete, accurate, readily accessible, and systematically organized medical records.</p> <p>All current residents are weighed weekly or daily as ordered.</p> <p>At morning interdisciplinary team meeting all patients' current weights will be reviewed. The DON and Administrator will use weight loss notification form to provide communication to Provider and interdisciplinary team. This</p>		

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F 514	<p>Continued From page 19</p> <p>Resident progress notes for nursing (nursing notes - NN) dated 1/4/15 and 1/6/15 documented the resident had +2 edema to lower extremities. NN dated 1/7 and 1/8/15 did not document edema to any part of the resident's body. The record did not include NN on 1/9/15 for any of the shifts that addressed the resident's edema, weight loss or when and who was notified of the weight loss.</p> <p>On 1/9/15 at 7:55 AM, resident progress notes, documented a dietary entry for a "14 day review..." The note included the resident's weight was "stable." There were no other dietary notes for 1/9/15 related to the 8.2 pound weight loss.</p> <p>The resident's record did not include a physician's progress note for 1/9/15.</p> <p>On 1/23/15 at 10:07 AM, the resident was asked about the weight loss. She stated she believed it was because she had "a lot of swelling." The resident stated her leg was still "really swollen" and pointed to her right leg. The right leg was visibly larger than the left, as observed through the resident's slacks.</p> <p>On 1/23/15 at 1:35 PM, the DON explained the new weight process that had been implemented after the recertification survey. The DON stated weights were now taken on every resident on Friday unless ordered differently. He stated the physician or NP comes in every Friday and reviews each resident's weight. If a resident has a weight loss of concern, the physician or the NP takes a look at it to see if it's edema, nausea/vomiting, or poor appetite and makes recommendations/writes orders as how to proceed. The DON stated the Dietary Manager</p>	F 514	<p>form will be signed by the MD/NP and scanned into the EMR for each resident.</p> <p>#3 Nurses have been educated on properly and timely provider notification. Residents requiring daily weights will be reviewed daily and Provider will be notified of any significant weight loss/gains. Nurses will document provider notification in the progress notes and will care plan any new interventions.</p> <p>Residents requiring a weekly weight will be reviewed on a weekly basis by DON or designee. Those with a significant weight loss/gains will be reported to the Provider and interdisciplinary team. Provider notification will be documented by licensed nurse and any interventions will be care planned accordingly. When surveyors arrive, facility staff will be available to assist them in accessing historical care plan data, as requested.</p>		

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F 514	<p>Continued From page 20</p> <p>was also provided the weight list. The DON was asked to provide a progress note from the physician which addressed the 8.2 pound weight loss for Resident #14 or a NN that documented the physician was notified on 1/9/15 and the weight loss was addressed.</p> <p>On 1/23/15 at 3:15 PM, the DON stated, "Unfortunately my nurses did not document anything on that date." The DON stated he had talked to the NP who had initialed at the bottom of the Friday Weight Day form. The DON stated the NP was not concerned about the weight loss due to the resident had started on the diuretic. The DON was asked if he found a note documenting the NP had assessed the resident related to the 8.2 pound weight loss. The DON stated there could be a dictation but sometimes it took "up to 4 to 5 weeks" to get it back. When asked if it always took that long, he stated, "Sometimes it can be the same week." The DON said he would check to see if a note addressing edema or weight loss had been dictated by the NP on 1/9/15. None was provided.</p> <p>On 1/23/15 at 4:45 PM, the Administrator and the DON were informed of the findings. No additional information was provided.</p> <p>2. Resident #17 was admitted to the facility on 12/19/14 for rehabilitation of a joint replacement and unspecified essential hypertension.</p> <p>Nursing and other discipline care provided to the resident was documented in an electronic medical record (EMR). The program allowed for changes to be made to a care plan. The electronic record program would keep the date the original documentation was made, but not put</p>	F 514	<p>#4</p> <p>DON or designee will conduct a random weekly audit on 4 residents for 3 months to ensure accuracy and accountability of each resident's medical records and ensure the Provider and interdisciplinary team have been notified and nursing notes reflect changes and Provider notification.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A Compliance Officer representing the Board will visit the facility Q month to complete compliance review.</p> <p>A Nurse Consultant will assist with auditing system as requested</p> <p>#5 Date of completion: 2/23/15</p>		

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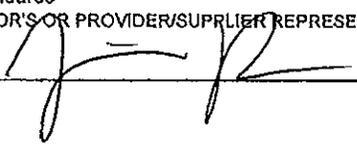
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F 514	<p>Continued From page 21</p> <p>the date the changes were made. This process made it difficult to determine when care plan changes were made because the dates on the review document provided to surveyors were the dates the original plan was developed. The surveyor had to request an historical review of each focus, goal, and intervention to determine when the change actually occurred.</p> <p>The EMR documented the resident's Nutritional Evaluation was started on 12/26/14 and signed by the Dietitian on 1/23/15. It is unclear when the dietitian actually interacted with the resident to do the evaluation.</p> <p>Additionally, the resident's skin care plan, with dates of initiation documented: Focus: "(Resident Name) has a pressure ulcer development r/t (related to) mobility limitations and bowel incontinence." The documentation was dated 12/19/14, however an historical review of the plan revealed the modification actually took place on 1/14/15.</p> <p>Please refer to F314 for details.</p>	F 514			

Bureau of Facility Standards

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{C 000}	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual state licensure follow-up survey of your facility. The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Susan Gollobit, RN	{C 000}		
{C 789}	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to pressure sores.	{C 789}	<u>C 789</u> 02.200,03,b,v Refer to F 314	2/23/15
{C 792}	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Refer to F323 as it relates to safety assessments.	{C 792}	<u>C 792</u> 02.200,03,b,viii Refer to F 323	2/23/15
C 887	02.203,02,f Progress Notes f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health	C 887	<u>C 887</u> 02.203,02,f	2/23/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	2/18/15

Bureau of Facility Standards

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C 887	Continued From page 1 care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. This Rule is not met as evidenced by: refer to F514 for complete resident record documentation.	C 887	Refer to F 514	