



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

FILE COPY

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
FAX 208-364-1888

March 19, 2015

Jon F. Smith, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Smith:

On **February 27, 2015**, a survey was conducted at Caribou Memorial Living Center 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 an isolated deficiency that constitutes actual 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. 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.) **Please provide ONLY ONE completion date for each federal 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 the Form CMS-2567, Statement of Deficiencies and Plan of Correction in the spaces provided and return the original to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 1, 2015**. Failure

to submit an acceptable PoC by **April 1, 2015**, may result in the imposition of civil monetary penalties by **April 21, 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 27, 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 &

Jon F. Smith, Administrator
March 19, 2015
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Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option 2, Fax #: (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. 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 **April 1, 2015**. If your request for informal dispute resolution is received after **April 1, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



Nina Sanderson L.S.W, Supervisor
Long Term Care

NS/dmj
Enclosures

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

PRINTED: 03/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2016
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276	
(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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Ashley Henscheld, QIDP</p> <p>The survey team entered the facility on February 23, 2016, and exited on February 27, 2016.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CM = Centimeters CFO = Chief Financial Officer CHF = Congestive Heart Failure CNA = Certified Nurse Aide CNO = Chief Nursing Officer HTN = Hypertension IM = Intramuscular IP = Infection Preventionist LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram ML/ml = Milliliter NOS = Not otherwise specified PO = Per Oral PRN = As Needed PT = Physical Therapy PTO = Physician Telephone Orders Q = Every SW = Social Worker TAR = Treatment Administration Record TED = Anti-embolism stockings</p>	F 000	<p>RECEIVED</p> <p>APR 23 2016</p> <p>FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jon Smith

CEO

4/28/15

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 000 F 167 SS=C	<p>Continued From page 1 WN = Wound Nurse</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility did not ensure the results of the annual recertification survey were readily accessible to residents for any resident or their representative who may want to review the survey results, including 10 of 10 sampled residents (Residents #1 - 10) and 2 of 8 residents in the group interview with surveyors. The findings included:</p> <p>1. An environmental review was conducted with the facility's Maintenance Supervisor on 2/24/15 from 9:30 - 10:38 a.m. When asked about survey results, the Maintenance Supervisor obtained a binder from the nurse's station. The binder contained the most recent fire, life, safety survey results. The Maintenance Supervisor stated he placed the most recent fire, life, safety results in the binder. He stated he thought it was where the survey results for the last annual recertification</p>	F 000 F 167	<p>F 167 Corrective Action: The results of the most recent survey have been posted on the wall at the entrance to the main hallway in the Long-Term Care unit. They are in a binder that sets in a wall caddy. A notice of their availability has been posted above the wall caddy indicating "Results of Most Recent State/Federal Survey". This binder is accessible to residents/Family/Staff/Visitors.</p> <p>Systemic Changes: 1. The CEO will provide education to department managers regarding regulations on accessibility and posting of surveys. 2. "Survey Results" were added as an agenda item for monthly resident council meetings. The Social Worker will remind residents during Resident Council where the survey results are located, and that they have the right to review them.</p> <p>Monitoring: The CEO/designee will conduct random monitoring 3x per week to validate survey results are accessible to residents and a notice of their availability are posted. The CEO/designee will report any identified trends as needed and quarterly/monthly to the Quality Assurance Performance Committee until a lesser frequency is deemed appropriate by the committee.</p> <p><i>5.7.15 11:30 AM DVS SAID SW WILL SPEAK WITH OTHER RESIDENTS WHO DO NOT ATTEND RESIDENT COUNCIL. Km Telephone conversation</i></p>	4/15/15

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F 167	Continued From page 2 survey were supposed to be kept as well, however, they were not in the binder. Additionally, there was a plaque in the hall, near the entrance, directing readers to the nurse's station for survey results. The nurse's station also had a plaque, directing readers to reference the "above binder" for survey results. However, when the binder was observed it was stored behind the counter of the nurse's station. The CNO was asked about the binder and survey results on 2/24/15 at 10:41 a.m. The CNO stated the results of the last recertification survey should have been accessible in the binder. She stated the results had been in the binder recently and must have been removed. On 2/24/15 at 11:00 a.m., the CNO showed surveyors that the last recertification survey results had been re-printed and filed in the binder. During a group interview, on 2/25/15 from 9:05 - 10:05 a.m., 2 of 8 residents stated they did not know where the survey binder was located. During the exit conference on 2/27/15 from 3:47 - 4:03 p.m., the Administrator was informed of the surveyor's findings. The facility offered no further information. The facility failed to ensure survey results were readily accessible to residents.	F 167			
F 225 SS=D	483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225			

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F 225	<p>Continued From page 3</p> <p>been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to</p>	F 225	<p>F-225</p> <p>Corrective Actions: Resident #10 is deceased (11/22/14) Resident #6 will be reassessed for psychological harm, the care plan will be updated, and the responsible party and attending physician will be notified with any new orders noted as applicable. Identification of others potentially affected: Residents currently residing in the Living Center will be interviewed and assessed as applicable for signs and symptoms of abuse. Any identified concerns will be investigated timely and resident protected, care plan updated, reported to appropriate authorities and responsible party and attending Physician notified if applicable. Systemic Change: 1. The CEO/designee will be responsible for providing further education to the Interdisciplinary Team on policy and procedures related to Abuse Allegation Investigation including the required interviews of other residents and staff members not involved in the event and protecting the resident(s) immediately upon notification of alleged abuse. 2. The CNO/designee will be responsible for providing further education to front line staff on the definition of abuse, signs and symptoms, corrective actions including reporting requirements and applicable documentation and care planning. 3. The Social Worker/Designee will conduct random interviews of 10 staff per month regarding their understanding of the abuse policy and procedures. Any concerns will be addressed immediately. Results will be logged and reviewed with IDT/QAPI as needed. Monitoring: The CEO/designee will be responsible for conducting random reviews 3 times a week of any alleged allegation of abuse to validate that the investigation was thorough, accurate and timely and resident was protected immediately. Any deficient practice will be corrected. The CNO/designee will be responsible for conducting random reviews 3 times a week of any alleged</p>	5/15/15	

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F 225	<p>Continued From page 4</p> <p>ensure residents were immediately protected and a thorough investigation was conducted for all allegations of abuse, neglect, and mistreatment for 2 of 4 residents (Residents #6 and #10) involved in significant incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions and the potential for on-going abuse prior to resident protection. The findings included, but were not limited to, the following:</p> <p>The facility's Abuse Prevention policy, dated 10/26/14, documented staff were to immediately report any incident of possible abuse or neglect to the Charge Nurse, who "will take appropriate immediate action to ensure the safety of all residents...All alleged violations will be investigated thoroughly by the Licensed Social Worker and/or a designee."</p> <p>1. An investigation, dated 3/25/14, documented Resident #10 was being bathed by CNA #1 and CNA #2 when CNA #2 allegedly sprayed Resident #10 in the face with water using the shower wand. However, the investigation was not thorough, as follows:</p> <p>a. The investigation was composed of a written statement from each CNA, as well as the typed results of verbal interviews with the facility's Social Worker.</p> <p>No documentation of an interview with Resident #10, or any information related to why Resident #10 was not interviewed, could be found.</p> <p>b. The investigation documented "Administration determined [CNA #2's] behavior was not intentional and she could return to work."</p>	F 225	<p>(F-225 continued)</p> <p>allegation of abuse to validate that the event was reported timely, and documentation and care planning are accurate and timely. Any deficient practice will be corrected. The CNO/designee will be responsible for conducting random interviews with front line staff to validate understanding of the definition of abuse and signs and symptoms of abuse. Any deficient practice will be corrected. Quality Assurance and Performance Improvement: Any identified trends noted from monitoring events will be reported to the Quality Assurance Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>		

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F 225	<p>Continued From page 5</p> <p>However, the documentation did not include information related to how that conclusion was reached.</p> <p>The report did not document that any staff or other residents were interviewed or that a review of data for patterns in similar incidents was conducted.</p> <p>When asked about the composition of "administration," during an interview on 2/24/16 from 1:58 - 2:10 p.m., the Social Worker stated the team included herself, the Administrator, the CNO and the former manager. The Social Worker stated Resident #10 had dementia and was non-interviewable because she spoke in a nonsensical manner. She stated there was never a discussion amongst the administrative team to do further investigation.</p> <p>During an interview on 2/25/16 from 8:40 - 10:10 a.m., the former manager stated Resident #10 had severe dementia and was non-interviewable. The former manager stated CNA #1 and CNA #2 were the only people interviewed because they were the only ones in the room with Resident #10. She stated the administrative team concluded CNA #2's behavior was not intentional because CNA #2 stated it was not.</p> <p>In an interview on 2/25/16 from 1:09 - 1:33 p.m., the Administrator stated the investigation ended with a "he-said, she-said" situation. He stated there was no way to find more information than that. When asked if he had talked to other people about CNA#2, Resident #10 and/or their interactions, he stated he could not remember.</p>	F 225			

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F 225	Continued From page 6 The facility failed to ensure the allegation involving Resident #10 was thoroughly investigated. 2. An investigation, signed by the Social Worker on 1/28/15, documented Resident #6 was in the corner of the dining room with CNA #3 for breakfast and the two were not getting along. Witness statements included allegations of CNA #3 yelling and "swatting" at Resident #6. The incident was reported on 1/21/15 at approximately 11:30 a.m. The investigation documented "[CNA #3] was suspended from her scheduled shifts throughout the remainder of the investigation." The investigation documented CNA #3 was interviewed that day (1/21/15) from 1:35 - 1:45 p.m. No details related to the time and date of CNA #3's suspension were included in the documentation. On 2/26/15 at 11:15 a.m., the CFO provided documentation that CNA #3 clocked out at 2:00 p.m. When asked what precautions were put in place to ensure resident protection from 11:30 a.m. - 2:00 p.m., the CFO stated there were none. The CFO stated CNA #3 continued working in the facility, providing care to residents, from the time the allegation was reported until she clocked out at 2:00 p.m. The facility failed to ensure residents were immediately protected following an allegation of abuse.	F 225			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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F 279	<p>Continued From page 7</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> <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 failed to ensure comprehensive care plans included interventions for 6 of 9 (Residents #s 2, 3, 5, 6, 7 and 10) whose care plans were reviewed. This failure had the potential for harm if residents did not receive the necessary care to meet their needs. Findings included:</p> <p>Initial care plans were reviewed, and did not include sufficient interventions, as follows:</p> <p>1. Resident #2 was admitted to the facility on with multiple diagnoses including congestive heart failure, hypertension, generalized pain and</p>	F 279	<p>F-279</p> <p>Corrective Actions:</p> <p>Resident #2 Cognitive loss, visual function, communication, urinary incontinence and indwelling catheter, falls, nutrition status, dehydration/fluid maintenance, pressure ulcer and psychotropic drug use interventions specific to these areas will be added to care plan as applicable.</p> <p>Resident #3 Cognitive loss, visual function, communication, urinary incontinence and indwelling catheter, falls, nutrition status and pressure ulcer interventions specific to these areas will be added to the care plan as applicable.</p> <p>Resident #5 Cognitive loss, ADL functional/ rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dental care, pressure ulcer, pressure ulcer and pain interventions specific to these areas will be added to the care plan as applicable.</p> <p>Resident #7 Cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, psychosocial wellbeing, mood state, behavior symptoms, activities, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use interventions specific to these areas will be added to the care plan as applicable.</p> <p>Resident #10 is deceased (11/22/14)</p> <p>Resident #1 Identified care area of communication will be added to the care plan as applicable.</p> <p>Resident #6 identified care area of dehydration/ fluid maintenance will be added to the care plan as applicable.</p> <p>Identification of other Residents Potentially Affected: MDS Care Area Assessment Summaries will be reviewed for residents currently residing in the Living Center. Any areas and/or specific interventions identified as missing will be added to the care plan.</p>	4/15/15	

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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	
F 279	<p>Continued From page 8 depressive disorder.</p> <p>The resident's 9/24/14 admission MDS and subsequent Care Area Assessment (CAA) Summary documented the following care areas were care planned: cognitive loss, visual function, communication, urinary incontinence and indwelling catheter, falls, nutrition status, dehydration/fluid maintenance, pressure ulcer and psychotropic drug use.</p> <p>The resident's care plan was reviewed and did not include interventions specific to the above identified care areas.</p> <p>2. Resident #3 was admitted to the facility on 12/1/14 with multiple diagnoses including congestive heart failure, dementia, hearing loss, nutrition deficiency and generalized pain.</p> <p>The resident's 9/18/14 annual MDS and subsequent Care Area Assessment (CAA) Summary documented the following care areas were care planned: cognitive loss, visual function, communication, urinary incontinence and indwelling catheter, falls, nutrition status, and pressure ulcer.</p> <p>The resident's care plan was reviewed and did not include interventions specific to the above identified care areas.</p> <p>3. Resident #5 was admitted to the facility with multiple diagnoses including pathological fracture unspecified site, depressive disorder, bipolar disorder, chronic pain syndrome, joint pain, and osteoporosis.</p> <p>The resident's 8/21/14 admission MDS and</p>	F 279	<p>(F-279 Continued)</p> <p>Systemic Changes: The CNO/designee will provide further training to the IDT including the MDS coordinator on the care planning process and the expectation of having an interdisciplinary approach identifying areas that require care planning and the need to individualize approaches of applicable Care Assessment Areas. The training will also include re-establishing interdisciplinary care conference on a routine basis to include resident/responsible party as applicable.</p> <p>Monitoring: The CNO/designee will review randomly 3 times a week MDS Care Assessment Area summaries to validate that the care plan reflects all aspects addressed and specific interventions as applicable.</p> <p>The CNO/designee will participate at a minimum of monthly in a scheduled/ad hoc IDT care conference to validate all appropriate team members including resident/responsible party are present and care planning has been done timely and accurately since last review.</p> <p>Quality Assurance and Performance Improvement: Any trends identified in the above monitoring activities will be corrected and reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>		

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F 279	<p>Continued From page 9</p> <p>subsequent Care Area Assessment (CAA) Summary documented the following care areas were care planned: cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use and pain.</p> <p>The resident's care plan was reviewed and did not include interventions specific to the above identified care areas.</p> <p>4. There were similar findings for Resident #7 and Resident #10.</p> <p>On 2/25/15 at 3:05 p.m., the CNO said the care plan interventions were not specific to the identified areas on the care plans.</p> <p>During the exit conference on 2/27/15 from 3:47 - 4:03 p.m., the Administrator, CNO and Social Worker were informed of the assessment concerns. However, no further information or documentation was provided which resolved the issues.</p> <p>The facility failed to ensure resident care plans included comprehensive, specific interventions for each assessed need.</p> <p>5. Resident #1 was admitted to the facility on 1/15/15 with multiple diagnoses which included muscle weakness, pleural effusion and congestive heart failure.</p> <p>The resident's Admission MDS Assessment, dated 1/21/15, documented in Section V a care planning decision for the problem of Communication. The MDS coded the resident had moderately impaired cognition skills with a</p>	F 279		

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F 279	<p>Continued From page 10 BIMS score of 12.</p> <p>Resident #1's Care Plan (CP) was reviewed. Although the resident's Admission MDS Section V triggered for the problem of Communication, the care area was not included in the resident's CP.</p> <p>On 2/26/15 at 1:20 PM, the CNO was asked about the Communication CP and stated, "There is not a care plan."</p> <p>6. Resident #6 was admitted to the facility on 10/16/14 with multiple diagnoses which included dementia and, on 12/26/14, was admitted to hospice with a diagnosis of senile degeneration of the brain.</p> <p>The resident's Admission MDS Assessment, dated 10/22/14, and Significant Change MDS Assessment, dated 1/1/15; both documented in Section V a care planning decision for the problem of Dehydration/Fluid Maintenance. Additionally, the MDS assessments coded the resident was severely cognitively impaired, and required a mechanically altered diet. The Admission MDS assessment, dated 10/22/14, documented the resident required limited assistance of one person for eating but did not have functional limitation in range of motion. The Significant Change MDS assessment, dated 1/1/15, documented the resident required extensive assistance of one person for eating and had impairment of functional limitation in range of motion on both sides.</p> <p>Resident #6's CP was reviewed. The resident's Admission and Significant Change MDS Section V triggered for the problem of Dehydration/Fluid Maintenance, however, the care area was not</p>	F 279		

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F 279	Continued From page 11 Included In the resident's CP.	F 279			
F 280 SS=E	<p>On 2/27/15 at 9:40 AM, the CNO and SW were informed of the MDS Care Area concerns and stated they agreed and understood they had care plan Issues.</p> <p>On 2/27/14 at 3:45 PM, the Administrator and CNO were made aware of the surveyors concerns with the care planning process. No further information was provided by the facility.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 280	<p>F-280</p> <p>Resident #1 will have any identified skin issues and related care and treatment added to the care plan. Identified nutritional needs related to poor appetite and prevention of weight loss and or skin breakdown will also be added if currently applicable.</p> <p>Resident #4 Removing the excessive tubing from the O2 as an intervention to reduce further falls has been added to the care plan.</p> <p>Resident #6 will be reassessed for current applicable fall prevention interventions including increased supervision, use of night light, non-skid footwear, pressure sensor and 1:1 observation and added with a date to the care plan. The care plan will also be updated to reflect non-pharmacological interventions related to Psychotropic drug use and hospice interventions including when to contact and frequency of Hospice team member visits.</p> <p>Resident #8 will be reviewed for current signs and symptoms related to a diagnosis of Chronic Psychosis. Identified signs and symptoms will be added to the care plan including the non-pharmacological interventions currently implemented.</p> <p>Resident #9 will be reviewed for current signs and symptoms related to a diagnosis of Dementia without behaviors. Identified signs and symptoms</p>	4/15/15	

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F 280	<p>Continued From page 12</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure resident care plans were reviewed and revised after there were changes in their status. This was true for 5 of 9 sampled residents (#s 1,4,6,8 and 9). This had the potential to result in harm should residents not receive the appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 1/15/15 with multiple diagnoses which included muscle weakness, pleural effusion and congestive heart failure.</p> <p>The resident's Admission MDS Assessment, dated 1/21/15, documented the resident needed limited assistance with 1 person assist for bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing. However, record review of Resident #1's Care Plan (CP) for Personal Cares, dated 1/16/15, documented the resident was able to shower with set-up assistance, and the Fall CP, dated 1/16/15, documented the resident was independent in her room.</p> <p>The resident's admission Wound & Skin Treatment Administration Record, documented the resident had moisture caused dermatitis on her coccyx and received treatment. The resident's CP for Pressure Ulcers documented the resident was at risk for pressure ulcers and skin breakdown but did not include any interventions on prevention or that the resident received treatment for skin breakdown. Additionally, record review of the resident's CP for Nutritional Status documented the resident's</p>	F 280	<p>(F-280 continued)</p> <p>will be added to the care plan including the non-pharmacological interventions currently implemented.</p> <p>Identification of other Residents Potentially Affected: The CNO/designee will establish a base line and review care plans for the residents currently residing in the Living Center, to validate care plans are up to date with pertinent care information and specific interventions as applicable.</p> <p>Systemic Changes: The CNO/designee will provide further training to the IDT, including the MDS coordinator, on the care planning process and the expectation of having an interdisciplinary approach to identifying areas that require care planning and the need to individualize approaches of applicable Care Assessment Areas as well as any changes during the resident's stay. The training will also include re-establishing inter-disciplinary care conference on a routine basis to include resident/responsible party as applicable.</p> <p>Monitoring: The CNO/designee will review randomly 3 times a week MDS Care Assessment Area summaries to validate care plan reflects all aspects addressed and specific interventions as applicable. The CNO/designee will review randomly 3 times a week residents who have had a change in condition and/or physician telephone orders to validate that any changes have been updated accurately and timely to the care plan. The CNO/designee will participate at a minimum of monthly in a scheduled/ad hoc IDT care conference to validate all appropriate team members including resident/responsible party and hospice staff as applicable are present and care planning has been done timely and accurately since last review.</p>	

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F 280	<p>Continued From page 13</p> <p>appelite was poor and did not include any interventions to help the resident improve her nutrition for prevention of weight loss or pressure ulcers.</p> <p>2. Resident #4 was admitted to the facility on 5/6/07 with multiple diagnoses which included seizure disorder and organic mental syndrome.</p> <p>Resident #4 fell on 12/2/14 as a result of getting tangled up in the oxygen tubing. Record review of the Incident Report, for the 12/2 fall, documented the new intervention to remove excessive length of oxygen tubing to prevent falls. However, this intervention was not found on the resident's CP for falls.</p> <p>On 2/25/15 at 3:05 PM, the CNO provided a copy of a Risk vs. Benefit for falls for Resident #4, dated 9/18/08, with care plan interventions which included to provide 1-2 person assist for transfers, ambulation and toilet use. It also included the resident frequently refused help, did not use his call light and was adamant for his need of independence. She stated the resident chose to be independent when he was in his room and that nothing had changed since 2008. She stated this plan of care should be reviewed and revised annually.</p> <p>3. Resident #6 was admitted to the facility on 10/16/14 with multiple diagnoses which included dementia and, on 12/26/14, was admitted to hospice with a diagnosis of senile degeneration of the brain.</p> <p>Resident #6 had multiple falls and the Fall Care Plan did not document interventions of increased supervision, use of a night light, non-skid</p>	F 280	<p>(F-280 continued)</p> <p>Quality Assurance and Performance Improvement: Any trends identified in the above monitoring activities will be corrected and reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>		

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F 280	<p>Continued From page 14</p> <p>footwear, pressure sensor, and 1:1 observation had been added to the care plan after each fall. Additionally, it could not be determined when interventions were initiated, updated or revised after the resident fell.</p> <p>Record review of the resident's Care Plan for Psychotropic Drug Use did not include non-pharmacological interventions. Additionally, the CP for hospice was reviewed and documented the problem of a deteriorating condition and diagnosis of senile degeneration of the brain, but did not document goals or a plan for coordination of services between the hospice agency and the facility. The CP did not include any hospice interventions of when to call hospice or how often hospice nurses, CNA's, social worker, or the chaplain would visit.</p> <p>4. Resident #8 was admitted to the facility on 12/18/09 with multiple diagnoses which included mild dementia, general deconditioning and chronic psychosis.</p> <p>Record review of the resident's Care Plan for Psychotropic Drug Use, initiated on 5/20/14, documented the resident took an antipsychotic medication for chronic psychosis, however, the care plan did not document what the chronic psychotic signs and symptoms were or include any non-pharmacological interventions.</p> <p>Similar results found for Resident #9.</p> <p>On 2/25/15 at 3:05 PM, the CNO stated she recognized there was a problem with care plan problem statements, goals, chronological processes and interventions were not specific. Additionally, she stated the care plans did not</p>	F 280			

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F 280	Continued From page 15 show they had been reviewed or revised.	F 280		
F 309 SS=D	<p>On 2/26/15 at 5:25 PM, the Administrator, CFO and CNO were made aware of the care plan concerns. No additional information was provided by the facility.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide coordinate the plan of care with hospice agencies in providing care and treatment. This was true for 1 of 9 (#6) sampled residents reviewed for hospice services. Findings included:</p> <p>Resident #6 was admitted to the facility on 10/16/14 with multiple diagnoses which included dementia and, on 12/26/14, was admitted to hospice with a diagnosis of senile degeneration of the brain.</p> <p>The resident's medical record did not include documentation that a coordinated plan of care had been identified between the facility and the hospice agency. No documentation was found which indicated what care and services the facility</p>	F 309	<p>F-309 Corrective Actions: Resident #6 care plan will be updated on what care and services hospice is providing including visit frequencies. Pertinent resident information including assessments will be added to the resident's medical record.</p> <p>Identification of other Residents Potentially Affected: The CNO/designee will review the medical records including the care plan of residents currently receiving hospice services to validate that care to be provided and frequency of visits has been added to the care plan and pertinent information including assessments are in place.</p> <p>Systemic Changes: 1. The CNO/designee will provide further education to the Hospice provider regarding the need to have collaboration of services including coordination of services noted on care plan and pertinent documentation/assessment available in the medical records of the residents that are receiving hospice services. 2. The CNO/designee will establish an IDT care meeting calendar and invite hospice care providers to attend in person or via phone to participate in updating the care plan as well as partnering in services to be provided.</p> <p>Monitoring: The CNO/designee will monitor 2 times a week, the medical records of residents receiving hospice services to validate that the care plan reflects coordination of care and pertinent documentation including assessment is maintained</p>	4/15/15

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F 309	Continued From page 16 would provide and what care and services the hospice agency would provide. Additionally, no documentation was found in the resident's medical record of communication with regard to hospice nursing assessments, social worker assessments, chaplain or CNA visits. On 2/27/15 at 9:00 AM, the CNO stated the facility had a contract with the hospice agency but did not have communication between the hospice agency and the facility. On 2/27/15 at 3:34 PM, the Administrator and CNO was made aware of the above mentioned concerns. No further information was provided by the facility.	F 309	(F-309 continued) in the medical record. Quality Assurance and Performance Improvement Any trends identified in above monitoring will be corrected and reported to the Quality Assurance and Performance Improvement committee as needed and monthly until a lesser frequency is deemed appropriate.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent the development of pressure ulcers. This was true for 3 of 9 (#s 2, 3, & 6) sampled residents. This failure created the potential for	F 314	F-314 Corrective Actions: Resident #3 has Hammertoes which were rubbing on her socks/shoes. Wound care has assessed and recommended taking her out of her shoes/socks and using non-skid slippers. A bed cradle was also added. Resident will be re-assessed for skin issues. Assessments and documentation will be completed per facility policy. Care plan will be updated with current assessment information and applicable interventions. Responsible party and attending physician will be notified. New Physician's orders will be noted as applicable. Resident #2's wound was resolved the day surveyors arrived at the facility. It was classified as a pressure ulcer from friction to the heel (believed to be caused by rubbing on the mattress (per wound care)). Interventions in place to prevent a recurrence include a compression boot while in bed and skin prep daily. Resident will be reassessed for skin problems. Assessments and documentation will be completed per center policy. Care plan will be updated with current assessment information and applicable	5/15/15

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F 314	<p>Continued From page 17 more than minimal harm when the facility failed to implement preventive measures and residents developed Stage II pressure ulcers. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 10/16/14 with multiple diagnoses which included dementia and, on 12/26/14, was admitted to hospice with a diagnosis of senile degeneration of the brain.</p> <p>The Significant Change MDS Assessment, dated 1/1/15, documented the resident was severely cognitively impaired with a BIMS score of 0, needed extensive assistance of 2 or more persons for transfers, dressing, toilet use and personal hygiene. Additionally, the resident was occasionally incontinent of urine and was at risk for pressure ulcers.</p> <p>A Braden Risk Assessment Report, dated 2/15/15, documented the resident was at high risk for skin breakdown.</p> <p>The Pressure Ulcer Care Plan, dated 2/17/15, documented the resident was at risk for pressure ulcers with approaches to observe the resident's skin when bathing or dressing and to report any reddened areas to the nurse for assessment and treatment.</p> <p>An Incident Report Form, dated 2/18/15 at 2:00 PM, documented Resident #6's skin stuck to the toilet seat, resulting in a 1.5 cm x 1.3 cm skin tear. The RN was notified and attempted to put the skin back in place. The skin tear was dressed with Bacitracin and covered with a wound dressing.</p>	F 314	<p>(F-314 continued) interventions. Responsible party and attending Physician will be notified. New Physician's orders will be noted as applicable. Resident #6's wound was caused from her skin sticking to the toilet seat and then sliding on the toilet seat. The wound nurse had assessed and provided a treatment plan. To prevent further skin problems, resident is off-loaded frequently and repositioned. Skin assessments weekly as scheduled. Resident will be reassessed for skin problems. Assessments and documentation will be completed per facility policy. Care plan will be updated with current assessment information and applicable interventions. Responsible party and attending physician will be notified. New physician orders will be noted as applicable and the care plan will be updated with applicable interventions. Systemic Changes: 1. The wound department/wound nurse will review skin assessments weekly and be responsible for staging of wounds and development of a treatment plan with the physician. Wound care will sign off on all resolved wounds. 2. The CNO/designee will provide further education to licensed nurses regarding classification, applicable interventions, and documentation including assessments and care plans. 3. The CNO/designee will provide further education to nursing staff related to pressure sore prevention. Monitoring: The CNO/designee will conduct random record reviews/interviews 3 times a week to validate accurate classification of wounds, that appropriate preventive measures have been implemented, as well as accurate documentation including assessments and care plans have been completed.</p>		

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PRINTED: 03/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2015
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276	
(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 314	<p>Continued From page 18</p> <p>A Wound Assessment Report (WAR) electronically signed by the MDS coordinator, dated 2/18/15, documented, "Skin Tear related to toileting, fragile skin stuck to toilet seat when being lifted. Area around wound is red but is blanchable...Edges not well approximated, all torn skin flaps present." Measurements documented - 1.50 cm Length (L) x 1.30 cm Width (W) x 0.10 cm Depth (D).</p> <p>A WAR by LN #4, dated 2/21/15, documented, "Skin flap is now missing...Started multlidx/algldex with dressing change (covaderm) q [every] 3 days and PRN until resolved." Measurements documented - 1.60 cm L x 1.10 cm W x 0.10 cm D.</p> <p>On 2/24/15 at 10:15 AM, the surveyor observed the resident's sacrum/coccyx in the presence of the Wound Nurse (WN) who stated this was the first time she had assessed the wound. The wound resembled an upside down fish hook which did not blanch at the top of the wound but did blanch on the right side and base of the wound. Bruising was noted on the left side of the wound and the area surrounding the wound was red and swollen.</p> <p>The WAR by the WN, dated 2/24/15, documented, "Upon assessment today, it is being classified as a Stage I/II Pressure Ulcer. Over all measurement is 5 CM [L] x 3 cm [W] with a small opening in the center measuring 0.5 cm round x 0.1 (Stage II). Blanching is noted along the right side of the wound up to the top (area is notably darker purple, from that area down the left side is non-blanchable. It appears to have edema present around wound. We will continue to use the algldex/multlidx on the wound and cover with</p>	F 314	(F-314 continued) Quality Assurance and Performance Improvement Any concerns identified with above monitoring will be corrected and any trends identified will be reported to the Quality Assurance and Performance Improvement committee as needed and monthly until a lesser frequency is deemed appropriate.	

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F 314	<p>Continued From page 19</p> <p>a pink foam sacral dressing and change daily. Resident is to be turned/repositioned every 2 hours. Family was not notified per their stated request not to be called for issues."</p> <p>On 2/27/16 at 8:10 AM, the Wound Nurse stated the resident's pressure ulcer was due to friction. She stated the need to offload and reposition the resident, including having the resident move every 30 minutes. She stated these interventions were added to the care plan.</p> <p>On 2/27/14 at 3:45 PM, the Administrator and CNO were made aware of the concern with pressure ulcers. No further information was provided by the facility.</p> <p>2. Resident #2 was admitted to the facility on 9/18/14 with diagnoses which included diabetes mellitus, type 2 and depression.</p> <p>Resident #2's admission MDS assessment, dated 9/24/14, documented Resident #2 was occasionally incontinent of urine and bowel and was at risk for pressure ulcers. The documentation indicated Resident #2 did not have any unhealed pressure ulcers at stage one or higher at the time of the assessment. The assessment also documented Resident #2 required extensive assistance with positioning, transfers, dressing, toilet use and personal hygiene. The most recent MDS assessment, dated 12/23/14, also documented Resident #2 did not have unhealed pressure ulcers.</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>Braden Risk Assessment Reports, dated 1/31/15, 2/12/15, 2/19/15 and 2/26/15, documented Resident #2 had a moderate risk for skin breakdown.</p> <p>Resident #2's care plan, dated 9/19/14, documented "I am at some risk for pressure ulcers due to the need to slide a little as I transfer from the sitting to standing position."</p> <p>The intervention in place was "Please observe my skin when bathing and dressing me and report any reddened areas to the nurse for assessment and treatment as needed." Additionally, for transfers the care plan documented "I require one person to assist me with a gait belt."</p> <p>An Incident Report Form, dated 1/4/15 and timed 9:00 p.m., documented "When putting [Resident #2] to bed, CNA's [sic] found a 4.5 cm x 3.5 cm water filled blister on [left] heel...Adaptic Kerlix put on for protection [and] padding of heel. Legs elevated [with] blue pillow to float heels. [Wound nurse name] to be informed..."</p> <p>During an observation with the facility's wound nurse on 2/27/14 at 8:00 a.m., Resident #2 was observed laying in bed, both heels were padded and elevated on a cushion. The wound nurse stated the resident had a clear water fluid blister to the left heel which developed in the facility. The wound nurse stated the blister had not been care planned. She unwrapped the heel which was observed to be healed and without redness.</p> <p>The facility failed to implement sufficient preventative care to ensure that Resident #2 did not develop a pressure ulcer after admission.</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>3. Resident #3 was admitted to the facility on 6/29/13 with diagnoses which included dementia and hypertension.</p> <p>The most recent MDS assessment, dated 12/18/14, documented Resident #3 was always incontinent of urine, frequently incontinent of bowel and was at risk for pressure ulcers. The documentation indicated Resident #3 did not have any unhealed pressure ulcers at stage one or higher at the time of the assessment. The assessment also documented Resident #3 was totally dependent with moving throughout the facility and bathing and required extensive assistance with positioning, transfers, dressing, eating, toilet use and personal hygiene.</p> <p>Braden Risk Assessment Reports, dated 2/6/15, 2/13/15 and 2/20/15, documented Resident #3 had a moderate risk for skin breakdown.</p> <p>Resident #3's care plan, dated 6/10/14, documented "I'm at risk for pressure ulcers and skin breakdown because I need assistance for bed mobility and transfers." The interventions in place were as follows:</p> <ul style="list-style-type: none"> - "Please assist me with repositioning at least every 2 hours." - "Please assist me with nutrition and hydration and keep my skin as clean and dry as possible." - "Inspect my skin when bathing or dressing me and report any issues to the nurse." - "I have a gel foam overlay on my bed as well as a pressure relieving device on my wheelchair." <p>Resident #3's record documented she developed a wound on her toe, via a General Notes entry, dated 1/2/15 and timed 7:56 a.m., which stated</p>	F 314		

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F 314	Continued From page 22 the facility's wound nurse was "informed of skin issues on coccyx and L second toe." A Wound Assessment Report, dated 2/6/15, documented Resident #3's left, third toe had "stage 2 partial thickness." The wound measured 0.2 cm long and 0.1 cm wide with no depth. Another General Notes entry, dated 2/23/15, documented "Apply Enlucra Humifiber drsg [dressing] to R, L 2nd toes. Right for Protection and Left for Pressure Ulcer partial thickness. Change every 10 days as needed." During an observation with the facility's wound nurse on 2/27/15 at 9:55 a.m., Resident #3's left second toe joint was observed to have a Stage II pressure ulcer which was healing without signs and symptoms of infection. The wound nurse stated Resident #3's pressure ulcer developed in the facility.	F 314			
F 323 SS=G	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	F 323	F-323 Corrective Actions: Resident #6 will be reassessed for fall risk, appropriate interventions including use of lap buddy, and care plan updated. Responsible party and attending physician notified and new orders noted as applicable. Resident #4 will be reassessed for fall risk, appropriate interventions including length of O2 tubing, and care plan updated. Responsible party and attending physician notified and new orders noted as applicable.	5/15/15	

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F 323	<p>Continued From page 23</p> <p>by:</p> <p>Based on record review, staff and resident interviews, it was determined the facility failed to ensure 3 of 9 resident's (#s 4, 8, & 10) were free from falls. Resident #4 was harmed when he fell and needed sutures. Resident #8 was harmed when she experienced 21 falls in a 9 week period of time with injuries which included a laceration to the head that required staples, a raised bump to the forehead and skin tears. Resident #10 experienced 4 falls when care plan interventions were not followed or revised after the resident fell. Additionally, the facility failed to evaluate the safety of physical restraints for 1 of 9 residents (#6). Resident #6 did not have a Lap Buddy safety assessment. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 10/16/14 with multiple diagnoses which included dementia and on 12/26/14, was admitted to hospice with a diagnosis of senile degeneration of the brain.</p> <p>The 10/22/14 admission MDS assessment documented the resident was severely cognitively impaired and needed limited assistance of one person for transfers, walking in the room, corridor, and on and off the unit.</p> <p>The 1/1/15 Significant Change assessment documented the resident was severely cognitively impaired and needed extensive assistance of 2+ persons for transfers, walking in the room, corridor and on and off the unit.</p> <p>The resident's 10/16/14 Fall Risk Assessment documented the resident as at high risk for falls.</p> <p>The fall care plan interventions in place prior to</p>	F 323	<p>(F-323 continued)</p> <p>Resident #10 is deceased (11/22/14)</p> <p>Identification of Other Residents Potentially Affected</p> <p>Current residents will be reassessed for fall risk, appropriate interventions including safety devices and care plans updated. Responsible parties and attending physicians will be notified and any new orders will be noted as applicable.</p> <p>Systemic Changes: The QAPI team has identified the root cause of falls as inconsistency in supervision of the IDT, and inconsistency in coordination of the IDT in relation to reviewing falls, determining root cause and review/updating of care plans. The IDT has also identified that lack of a restorative program has affected the residents muscle strength and balance, which has resulted in an increase in falls.</p> <ol style="list-style-type: none"> 1. The facility is in the process of re-implementing a restorative program. An ad has been placed for an RN, who will have as one of their responsibilities, oversight of the Restorative Program. There is currently one Restorative C.N.A. already in place, with four more C.N.A.'s being added to the program. The CNO/Designee will oversee the implementation of this program. 2. The facility will institute weekly environmental rounds to assess for possible contributing factors to falls. The IDT will review the results, and appropriate changes will be implemented as needed. The CNO/Designee will oversee this process. 3. The CNO will be responsible for providing further training to Living Center Leadership regarding fall risk and investigation forms, root cause, timely and accurate care planning and application of identified interventions. Training will also include documentation related to safety device assessments and consents as applicable. 4. Telephone Orders will be reviewed in morning team meeting (stand-up meeting) to verify that care plans are updated with current orders/treatments and for early recognition of change in condition. 		

5.7.14 11:30AM DMS
stated orders received
over the wknd (weekend)
will be reviewed at Monday
stand up. Weekend nurses
will be responsible for
care plan update and order
verification. KM
telephone conversation

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F 323	<p>Continued From page 24</p> <p>the resident's first fall on 10/28/14 documented to check on the resident frequently, but did not list how often frequently meant. Other interventions included PT evaluation on admit and PRN, mobility alarm/wander alarm, ensure non-skid footwear and to keep the environment clean and clutter free.</p> <p>Record review of Incident Reports (IR) documented Resident #6 fell six times between 10/28/14 to 11/14/14, which resulted in a skin tear to the resident's right elbow on 11/9/14. The interventions added to prevent falls documented: *10/28 - Motion sensor installed and night light in room, but was not added to the care plan; *11/4 - Continued observation, attempt to have resident sit with staff as able, but was not added to the care plan; *11/5 - Have finger foods available, but was not added to the care plan; *11/7 - Close observation, allow resident to walk by self, which was care planned; *11/9 - Increased supervision but was not added to the care plan; and, *11/14 - 1/2 hour checks, continue pressure sensor, point motion sensor at bed, but was not added to the care plan.</p> <p>On 11/14/14 a PT report documented the resident was not a rehab candidate due to her mental status and transfers, was able to ambulate pretty well, and was easily distracted. The resident's falls were due to her mental status and delusions rather than physical instability.</p> <p>Record review of Incident Reports (IR) documented Resident #6 fell 2 times between 11/15/14 to 11/17/14 without injury. The interventions to prevent falls included:</p>	F 323	<p>(F-323 Continued)</p> <p>5. Any fall will be reviewed in morning meeting to identify root cause, verify that the care plan was reviewed and new interventions added as applicable and that a falls risk was updated.</p> <p>6. The CNO/designee will be responsible for validating the quality, that fall risk meetings are occurring on a regular basis with Interdisciplinary Team (IDT) involvement and coordination.</p> <p>Monitoring: The CNO/designee will be responsible for random monitoring 3 times a week of documentation related to fall risk, fall investigation, identification of root cause, timely and appropriate implementation of interventions and care plans. The CNO/designee will also be responsible for random monitoring for documentation including assessments and consents related to safety devices identified as a fall risk intervention to validate accuracy, timeliness and application.</p> <p>Quality Assurance Performance Improvement: The CNO/designee will report findings as needed and monthly any identified trends to the Quality Assurance and Performance Improvement Committee until a lessor frequency is deemed appropriate.</p>		

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F 323	<p>Continued From page 25</p> <p>*11/15 - CNA to walk with resident with gait belt, staff to walk with resident when able when resident seems tired, but was not added to the care plan; and,</p> <p>*11/17 - 1:1 observation during the day and pursue alternate walker without wheels, but was not added to the care plan.</p> <p>An 11/17/14 Progress Note (PN) by the resident's physician documented the resident was having increased problems with falls but no injuries had occurred. The physician documented the resident had a very blank look in her eyes, wanted to walk without any reason or purpose, was unsteady and required almost one on one care both 11/16 and 11/17. The physician documented, "I understand that it is not appropriate to start anti-psychotics for just dementia behaviors but the patient is very obviously agitated and very obviously almost in a delirious type of a stupor, so I think it is well justified to at least start a light dose and possibly move this up over the next few days to see if it will help in any way to calm her down and calm down some of the restlessness. She is a very high fall risk." The Plan documented, "One on one observation whenever possible."</p> <p>Record review of an IR, dated 11/21/14, documented the resident fell without injury. The interventions added to prevent falls, documented 15 minute checks initially after the fall, continue to observe and keep areas clear of clutter which were care planned.</p> <p>An IR, dated 11/22/14 at 2:50 PM, documented the resident was found on the floor in the small TV room lying on her back between a recliner and the brick wall. Blood was noted on the brick wall and floor due to a laceration to the back of the</p>	F 323		

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F 323	<p>Continued From page 26</p> <p>resident's head. The resident was taken to a local hospital's emergency room for evaluation. The FSI (Fall Scene Investigation Report), for the 11/22/14 fall at 2:50 PM, documented the resident was confused, tearful and restless. She was ambulating prior to the fall with no goal in mind, was alone and unattended. The FSI did not document the root cause of the fall. The interventions added to prevent falls was 1:1 observation, which was not added to the care plan until 12/3/14. Additional interventions included Vital Signs/Neuro checks, which were not care planned.</p> <p>The Emergency Department Report, dated 11/22/14, documented the resident had a 5.5 cm vertical laceration from the crown of her head to mid-line of the back of the skull. The resident received 5 staples and the report documented there was some tissue missing at the base of the incision.</p> <p>An IR, dated 11/22/14 at 7:50 PM, documented the resident was found lying on the floor with her walker on top of her. A CNA witnessed the resident began to stiffen and lean backwards, then was on her back. The IR documented in the description of event, "Resident was placed in a wheel chair, then kept 1:1 with staff." In the follow-up section, the IR documented, "1:1 until resident appears stable." The 11/22/14 FSI for the 7:50 PM fall did not document a root cause had been determined. Additionally, the interventions added documented, "1:1 with staff," which were the same interventions added after the previous fall at 2:50 PM, earlier the same day.</p> <p>A NN, dated 11/23/14 at 12:04 AM, documented the 2:50 PM fall and the 7:50 PM, where she</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>again hit her head on the floor. The NN documented staples to the head were intact but the laceration had begun to bleed again. The resident was assessed, vital signs were taken and the resident was to have 1:1 supervision.</p> <p>An 11/28/14 PN by the resident's physician documented the resident continued to have problems with falls, was mentally compelled to walk in spite of being severely fatigued, and was not taking her medications well. The PN documented the resident had become aggressive, hitting at staff, and got angry when redirected from walking behaviors.</p> <p>Record review of IR's documented Resident #6 fell four times between 11/28/14 to 11/29/14 which resulted in a skin tear. The interventions added to prevent falls documented: *11/28 - 2 falls - One without injury and one with injury - a skin tear to the right shin. Interventions added were to ensure foot rest was not up unless staff were with the resident, which was not care planned; and, *11/29 - 2 falls without injuries, with interventions to continue to monitor as much as possible, which were not care planned, and encourage to rest when fatigued, which was added to the care plan on 12/2/14.</p> <p>On 12/2/14 the facility obtained a consent for a Lap Buddy restraint device to help Resident #6 with WC positioning. However, a safety assessment for the Lap Buddy was not found.</p> <p>A 12/3/14 NN documented, "Lap Buddy was implemented on 12/2/14 for positioning purposes when [resident] is in a w/c."</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>The resident's fall care plan documented a 12/2/14 intervention of a Lap Buddy to remind the resident to stay seated a little longer.</p> <p>Record review of the IRs documented Resident #6 fell five times between 12/3/14 to 12/20/14 with one injury. The interventions added to prevent falls documented:</p> <p>*12/3 - 2 falls - One fall with injury - a 1 cm raised bump to the forehead when ambulating in her room without assistance. The second fall did not have injury. Interventions added were to continue to monitor throughout the night when in bed, started a new order for Seroquel, an antipsychotic, at hour of sleep, and assign staff every 1/2 hour to provide 1:1 care to resident. All interventions were added to the care plan;</p> <p>*12/6 - Change motion sensor to pressure sensor on the bed, which was care planned;</p> <p>*12/12 - Continue to monitor closely when in bed, ensure walker is close by, slipper socks are on and pressure sensor is on. All interventions had been previously care planned. The IR documented, "Pt [patient] will be gotten up if still sleeping at this time of day when staff is busy and can't hear pressure alarms...is currently 1:1 during all D [day] and E [evening] hours;" and,</p> <p>*12/20 - Continue to follow along with care plan, non-skid socks, bed alarm and 1:1 while awake, which were previously care planned.</p> <p>A 12/22/14 PN by the resident's physician documented the physician had spoken with the resident's family member who stated the resident's delusional behaviors, hallucinations and almost psychosis ran in the family. The family member thought it was a hereditary-type of illness since it was from generation to generation. The physician documented the resident refused to</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>eat, was losing weight and would pursue hospice care.</p> <p>Record review of the IR documented Resident #6 fell on 1/1/15 without injury. The intervention added to prevent falls documented the resident remained a 1:1 observation during the day and evening, with close observation during sleeping hours. These interventions had been previously care planned.</p> <p>On 2/26/15 at 3:40 PM, the CNO stated the resident had periods of 1:1 observation which started on 11/17/14, and that the hours varied until the resident calmed down. She stated the actual intervention of 1:1 observation started on 12/3/14. The CNO stated she understood there were problems with care plans. When asked about the Lap Buddy device, the CNO stated there was a discussion with nursing at their Stand Up Meeting regarding the preferred method to help remind the resident to stay seated. It was felt the Lap Buddy would be the best option. The resident demonstrated that she could remove it herself. The CNO stated it had been care planned but the facility did not have a safety assessment.</p> <p>On 2/26/15 at 4:15 PM, the resident's physician stated the resident had a hereditary dementia, probably organic brain syndrome. The resident was very difficult to handle at first, was very angry, fidgety, hitting people but with the addition of Seroquel was now able to be in a chair and had calmed down. The physician stated, "I have never seen anyone so agitated when they first arrived and go without sleep." She stated she was involved in the decision regarding the Lap Buddy device but that it had not worked.</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>On 2/26/15 at 4:26 PM, the CNO stated, "We did a lot to help this resident and feel we did not give ourselves credit in the documentation. I don't know what else we could have done. Looking back, we could have instituted continuous 1:1 observation sooner." The CNO stated after the 11/22 fall, they instituted 1:1 continuously.</p> <p>The resident was assessed on admission to be a high fall risk and the facility failed to consistently implement interventions to prevent falls and the resident fell 21 times between 10/28/14 and 1/1/15. The facility failed to care plan interventions to prevent the resident from falling. The resident was harmed when she fell and needed 5 staples to the back of her head and then fell again the same day. The resident continued to fall after the intervention of continuous 1:1 supervision, however, it could not be determined if that was on 11/22/14 or 12/3/14. Additionally, a Lap Buddy restraint device was initiated without being assessed to be safe for this resident.</p> <p>2. Resident #4 was admitted to the facility on 5/6/07 with multiple diagnoses which included seizure disorder and organic mental syndrome.</p> <p>The 3/5/14 admission MDS assessment documented the resident was cognitively intact and needed extensive assistance of 2+ persons for bed mobility, transfers, walking in the room, dressing, and toilet use.</p> <p>The 12/4/14 quarterly MDS assessment documented the resident was cognitively intact and needed extensive assistance of 1 person for transfers and walking in the room. However, the resident needed limited assistance of 1 person</p>	F 323			

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F 323	<p>Continued From page 31 for bed mobility, dressing and toileting.</p> <p>The resident's 12/12/14 Fall Risk Assessment documented the resident was at high risk for falls.</p> <p>The fall care plan interventions, initiated on 7/24/14, documented the resident was at extremely high risk for falls because of instability. The care plan documented the resident needed to wear a helmet, use a walker and needed the assistance of one person when walking.</p> <p>An IR, dated 12/2/14 at 6:25 PM, documented Resident #4 fell in his room as a result of getting tangled up in his oxygen tubing. The resident had a laceration to the back of his head which was full of blood. He was taken to a local hospital's emergency room and six sutures were applied. The FSI documented the root cause of the fall was attributed to the length of the oxygen tubing with the plan to shorten the tubing in the resident's room. Additionally, the resident was educated to use his call light and wait for assistance. However, interventions to shorten the resident's oxygen tubing, re-education of call light usage or to wait for assistance were not found in the resident's care plan.</p> <p>The Emergency Department Report, dated 12/2/14, documented the resident actually had two lacerations to the crown of his head. One laceration measured 2.2 cm and the second laceration measured 1.5 cm and needed six sutures to approximate the lacerations.</p> <p>On 2/25/15 at 3:05 PM, the CNO provided a copy of a Risk vs. Benefit for falls for Resident #4, dated 9/18/08, with care plan interventions which included to provide 1-2 person assist for</p>	F 323		

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F 323	<p>Continued From page 32</p> <p>transfers, ambulation and toilet use. It documented the resident frequently refused help, did not use his call light and was adamant for his need of independence. The CNO stated the resident chose to be independent when he was in his room and that nothing had changed since 2008. She stated this plan of care should be reviewed and revised annually.</p> <p>On 2/26/15 at 11:15 AM, the CNO stated the resident fell at the door of his room when he became tangled up in the oxygen tubing. She stated since the extra tubing was the root cause of Resident #4's fall, an intervention should have been care planned.</p> <p>Resident #4 was harmed when he fell and needed medical evaluation and treatment for lacerations to his head which included sutures. The facility failed to care plan interventions to prevent future falls as a result of oxygen tubing length.</p> <p>On 2/26/15 at 5:25 PM, the Administrator and CNO were informed of the above mentioned concerns regarding falls. No further information was provided by the facility.</p> <p>3. Resident #10 was a 75 year old female admitted to the facility on 6/1/12 and readmitted to the facility on 11/10/14. Her diagnoses</p>	F 323			

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F 323	<p>Continued From page 33 Included dementia and depressive disorder.</p> <p>Resident #10's Care Plan, dated 6/15/14, included a section titled Falls which stated "I am at high risk for falls related to my balance problem, history of dizziness and unsteady gait. I have a significant history of falls due to my ability to still ambulate and transfer myself ... Please provide supervision and assistance as needed while I'm ambulating to ensure that I am safe. Please provide assistance as needed as I walk between different flooring transitions ... I have a monitor sensor in my room to notify staff when I am up and moving."</p> <p>A Care Plan Addendum, dated 9/29/14, stated Resident #10 had "unsteadiness and recent falls ... Many of my falls are because I am always bending over playing with my pants or socks or picking up imaginary items off the floor. Please watch for this behavior and help me as needed to prevent falls."</p> <p>However, Resident #10's record documented additional falls with no additional revisions to her care plan, as follows:</p> <p>- An Incident Report Form, dated 11/11/14 at 2:10 p.m., documented staff hear a scream and found Resident #10 sitting on the floor beside the couch in her room. The attached Fall Scene Investigation Report stated the fall was unwitnessed and no alarm was being used at the time of the fall. The Fall Scene Investigation Report stated Resident #10 had been "with a staff member 1:1 all day." Resident #10 refused to lie down when asked by the staff "so she was sat on the couch in her room."</p>	F 323			

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F 323	Continued From page 34 - An Incident Report Form, dated 11/12/13 at 8:30 p.m., documented Resident #10 was found on the floor of the dining room. The Fall Scene Investigation Report stated Resident #10 was alone and unattended at the time of the fall and that she "needs to be 1:1 when awake for her own safety." - An Incident Report Form, dated 11/13/14 at 5:10 p.m., documented Resident #10 was "found lying on floor in lounge [after] hearing loud cry." The attached Fall Scene Investigation Report stated the fall was unwitnessed and no alarm or preventative assistance was in place at the time of the fall. - An Incident Report Form, dated 11/15/14 at 7:15 a.m., documented a CNA found Resident #10 lying on the floor in the dining room. The attached Fall Scene Investigation Report stated Resident #10 had been trying to get out of bed earlier in the morning and had been "tearful" when taken to the dining room for breakfast. The report stated the fall was unwitnessed and no alarm or preventative assistance was in place at the time of the fall. On 2/27/15 from 3:47 - 4:03 p.m., the Administrator, CNO and Social Worker were informed of the concerns with falls. However, no further information or documentation was provided which resolved the issues. The facility failed to take sufficient precautions to ensure Resident #10 did not sustain falls.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328			

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F 328	<p>Continued From page 35</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; 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 interviews, it was determined the facility failed to ensure residents received oxygen at the liter flow ordered by the physician and had a physician's order which prescribed the liter flow. This was true for 2 of 9 (#s 1 & 4) sampled residents reviewed for the proper care and treatment of oxygen therapy. This deficient practice created the potential for harm should residents become anxious, confused and experience respiratory distress. Findings included:</p> <p>Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, documented on p. 269, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."</p> <p>1. Resident #4 was admitted to the facility on</p>	F 328	<p>F-328</p> <p>Corrective Actions: Resident #4 pulmonary system will be reassessed. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders obtained/clarified and noted. Care plan updated as applicable. Resident #1 pulmonary system will be reassessed. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders obtained/clarified and noted and Care plan updated as applicable.</p> <p>Identification of other Residents Potentially Affected: The CNO/designee will review all residents receiving O2 to validate orders are correct/clarified, O2 is available, and administered per physician orders.</p> <p>Systemic Changes: 1. Telephone Orders will be reviewed in Morning Meeting (Stand-up meeting) to verify that they are written correctly and placed on the eTAR correctly. Any corrections to orders will be made at this time. 2. The CNO/designee will provide further education to licensed nurses regarding elements required when obtaining physician orders for O2 administration. 3. The CNO/designee will provide further education to nursing staff on O2 availability, usage review monitoring. Monitoring: 4. The CNO/designee will conduct random reviews/interviews 3 times a week to validate appropriate O2 orders, documentation and administration of O2.</p> <p>Quality Assurance and Performance Improvement: Any concerns identified in above monitoring will be corrected and any identified trends will be reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>	5/15/15

Telephone conversation
5.7.15 11:30 AM DYS
weekend nurses have a
reference sheet that contains
all oxygen order components.
The nurse will contact the MD
when an order does not contain
all components. km

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F 328	<p>Continued From page 36</p> <p>5/8/07 with multiple diagnoses which included seizure disorder and organic mental syndrome.</p> <p>The February 2015 Physician's Orders (recapitulation) documented the following 11/30/12 oxygen order: "Oxygen @ [at] 1-4 Liters to keep sats > 88% [saturation greater than 88%]."</p> <p>On 2/25/15 at 10:05 AM, Resident #4 was observed in the Lounge with a portable oxygen tank which was empty. The surveyor showed the empty oxygen tank to LN #5 who acknowledged the tank was empty. She immediately took the portable oxygen tank to refill it. LN #5 checked the resident's saturations which were at 87% and then replaced the oxygen nasal cannula tubing on the resident.</p> <p>2. Resident #1 was admitted to the facility on 1/15/15 with multiple diagnoses which included muscle weakness, pleural effusion and congestive heart failure.</p> <p>The resident's 1/15/15 Admission Orders and February 2015 Physician's Orders, both documented, "O2 [oxygen] to keep > 88 [%]."</p> <p>However, the medical record did not include an order for liter flow.</p> <p>The MAR/TARs for January and February 2015, documented the resident received oxygen liter flow ranging from 1-3 liters.</p> <p>On 2/26/15 at 2:25 PM, the CNO stated the oxygen order should have been clarified.</p> <p>On 2/26/15 at 5:25 PM, the Administrator and CNO were made aware of the oxygen concerns.</p>	F 328		

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F 328	Continued From page 37 No further information was provided by the facility.	F 328		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 9 sampled residents (#4) was free from unnecessary medications. The facility failed to provide justification for duplicate therapy and to	F 329	F-329 Corrective Actions: Resident #4 will be reviewed for unnecessary medications and gradual dose reduction by attending physician. New physician orders will be noted, consents obtained, responsible party notified, behavior monitoring implemented and care plan updated. Identification of other Residents Potentially Affected: The CNO/designee will review medication regimens of the residents currently residing in the center to validate appropriateness of medication and that any concerns identified have appropriate justification documented by the attending physician. The review will also include appropriate and timely review of medications requiring gradual dosage attempts per regulations. Systemic Changes: 1. Telephone Orders will be reviewed at morning meeting (Stand-up meeting). Any medication ordered will be assessed at that time for duplicate therapy. Corrections and/or necessary documentation by the physician will be made/requested at this time. 2. The CNO/designee will provide further education to licensed staff and IDT regarding unnecessary medications and required gradual dosage attempts. 3. The CNO/designee will create and maintain a log of all residents on medications requiring GDR. The log will indicate the medication, dose changes, last GDR done and time for next GDR attempt. Monitoring: The CNO/designee will review Psychotropic Meeting minutes and or participate in monthly Psychotropic Meetings to validate residents receiving psychotropic medications are not receiving unnecessary drugs/or physician	5/15/15

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F 329	<p>Continued From page 38</p> <p>ensure gradual dose reductions for a resident (#4), who received antipsychotic and antidepressant medication. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>Resident #4 was admitted to the facility on 5/6/07 with multiple diagnoses which included seizure disorder and organic mental syndrome.</p> <p>The 12/4/14 Quarterly MDS Assessment documented the resident was cognitively intact, exhibited signs and symptoms of minimal depression, and did not exhibit signs or symptoms of psychosis. Additionally, the resident received antipsychotic and antidepressant medication.</p> <p>The resident's 2/1/15 Physician's Orders (recapitulation) documented the following orders: *Wellbutrin 75 mg Tab One Q (every) Day PO for the diagnosis of depression, with a start date of 9/1/11; *Celexa 20 mg Tab One Q Day PO for the diagnosis of depression, with a start date of 2/1/15; and, *Risperidone 1 mg Tab One BID PO for the diagnosis of organic brain syndrome, with a start date of 10/1/09.</p> <p>The February 2015 MAR documented the resident received Wellbutrin and Celexa daily, and Risperidone twice daily.</p> <p>Record review of the Psychotropic Interdisciplinary Medication Review (PIMR), dated 1/5/15 and 2/2/15, documented the resident had symptoms of withdrawal from activities of interest,</p>	F 329	<p>(F-329 continued)</p> <p>justification of usage has been documented in the record and gradual dose reductions are attempted timely.</p> <p>Quality Assurance and Performance Improvement: Concerns identified in above monitoring will be corrected and any trends identified will be reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>	

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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
F 329	Continued From page 39 had poor sleep habits and requested to keep his lights off during the day because it bothered his eyes. No documentation was found in the resident's medical record for the justification of two antidepressant medications. The PIMR for 1/5/15 and 2/2/14, documented Wellbutrin, an antidepressant, and Risperidone, an antipsychotic medication, were managed by the resident's neurologist. The resident's medical record did not include documentation by the neurologist a gradual dose reduction (GDR) had been attempted or addressed for Wellbutrin or Risperidone. On 2/26/15 at 11:15 AM, the CNO stated she did not have justification for duplicate therapy. She stated the resident's neurologist would have the gradual dose reduction information but she did not have documentation in the resident's medical record. On 2/26/15 at 5:25 PM, the Administrator and CNO were made aware of the concerns regarding unnecessary medications. No further information was provided by the facility.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F-431 Corrective Actions: Resident #2 will be assessed for signs and symptoms of hypo/hyperglycemia. Expired medication has been discarded and replaced and correctly dated. Resident #9 will be assessed for signs and symptoms of hypo/hyperglycemia. Expired medication has been discarded and replaced and correctly dated. Resident #11 will be assessed for signs and symptoms of hypo/hyperglycemia. Expired medication has been discarded and replaced and correctly dated.	4/15/15

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F 431	<p>Continued From page 40</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the manufacturers' label recommendations, it was determined the facility failed to ensure medications were disposed of and not available for use after the recommended expiration dates. This was true for 2 of 10 (#2, #9) sampled residents and 3 of 3 (#11, #12, #13) random residents. This deficient practice created the potential for harm as the residents would not receive the full benefit of the medications, should the medications be administered, after the recommended expiration dates. Findings</p>	F 431	<p>(F-431 Continued)</p> <p>Resident #12 will be assessed for signs and symptoms of hypo/hyperglycemia. Expired medication has been discarded and replaced and correctly dated.</p> <p>Resident #13 will be assessed for signs and symptoms of hypo/hyperglycemia. Expired medication has been discarded and replaced and correctly dated.</p> <p>Identification of other Residents Potentially Affected: The CNO/designee will conduct a sweep of all medications and treatments to validate correct dating of expirations. Any expired or undated medications/treatments will be discarded and replaced.</p> <p>Systemic Changes: The CNO/designee will provide further education to licensed staff and establish a schedule for cart audits to check for expired or un-dated medication/treatments.</p> <p>Monitoring: The CNO/designee will conduct random reviews 3 times a week of medication and treatment carts to validate medication and treatments are correctly dated and within expiration date.</p> <p>Quality Assurance and Performance Improvement: Concerns identified in above monitoring will be corrected and any trends identified will be reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>		

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F 431	<p>Continued From page 41 Included:</p> <p>During the drug storage observation on 2/25/15 at 11:15 a.m., 10 ml vials, which were opened and available for use, were beyond the 28 day recommended storage date for the identified residents as follows:</p> <ol style="list-style-type: none"> 1. Resident #2 was admitted to the facility with multiple diagnoses including diabetes mellitus. - Lantus vial approximately 1/4th full. The bottle contained a smudged and indistinguishable date. 2. Resident #9 was admitted to the facility with multiple diagnoses including diabetes mellitus. - Lantus vial approximately 1/3rd full. There was no opened date on the box or bottle. 3. Resident #11 was admitted to the facility with multiple diagnoses including uncontrolled diabetes mellitus. - Lantus vial, approximately 3/4th's full, opened 1/20/15, 8 days beyond the recommended discard date; and Novolog vial less than 1/2 full. There was no opened date on the Novolog box or bottle. 4. Resident #12 was admitted to the facility with multiple diagnoses including uncontrolled diabetes mellitus. - Lantus vial, approximately 1/8th full, opened 1/13/15, 15 days beyond the recommended discard date. 5. Resident #13 was admitted to the facility with multiple diagnoses including uncontrolled diabetes mellitus and stage III chronic kidney disease. - Humalog vial, approximately 1/8th full, opened 	F 431			

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F 431	Continued From page 42 1/12/15, 16 days beyond the recommended discard date. On 2/25/15 at 11:30 a.m., LN #5 stated the above identified medications should have been discarded 30 days after opening. Note: Review of the manufacturer's recommendations for the above identified medications, revealed the following: - In-use Humalog Vials Storage and Handling, "...must be used within 28 days or be discarded..." - Open (In-Use) Lantus Vials, "...Once...opened...should be discarded 28 days after the first use even if it still contains LANTUS..." - Novolog Vials, "...Recommended Storage...after initial use...for up to 28 days..."	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F-441 Corrective Actions: Resident #1 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #2 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #3 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable.	4/15/15	

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F 441	<p>Continued From page 43 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Infection Control Policy and Procedures and staff interview, it was determined the facility failed to ensure the policy and procedures included podiatry. This was true for 9 of 9 (#s 1-9) sample residents and all residents who resided in the facility. This practice could potentially harm residents by cross-contamination of bacteria, viruses and other microorganisms. Findings included: Review of the facility's current Infection Control Policy and Procedures revealed the policy and</p>	F 441	<p>(F-441 Continued) Resident #4 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #5 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #6 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #7 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #8 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Resident #9 will be assessed for signs and symptoms of infection. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Identification of other Residents Potentially Affected: The CNO/designee will conduct a sweep of residents who received recent (within last 14 days) podiatry services, for signs and symptoms of infection. Pertinent findings will be reported to attending physicians, orders noted, care plans updated and responsible parties notified as applicable.</p>	

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F 441	Continued From page 44 procedures did not include procedures for cleaning and disinfecting of podiatry equipment. On 2/27/15 at 8:15 a.m. during an interview, the Infection Preventionist reviewed the policy and procedures and said the facility did not include the cleaning and disinfecting of podiatry equipment in the policy and procedures. On 2/26/15 at 5:25 p.m., the Administrator and the CNO were informed of the finding. The facility did not provide any additional information.	F 441	(F-441 continued) Systemic Changes: A disinfecting podiatry equipment policy will be added to the Living Center Policies and Procedures and appropriate staff trained. The CNO/designee will be responsible. Monitoring: The CNO/designee will conduct random observation weekly to validate that podiatry equipment is properly sanitized between resident use. Quality Assurance and Performance Improvement: Concerns identified in above monitoring will be corrected and any identified trends will be reported to the Quality Assurance and Performance Improvement Committee as needed and monthly until a lesser frequency is deemed appropriate.		
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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident clinical records were accurately maintained. This was true for 1 of 9 (#1) sampled residents. This practice created the potential for care decisions to be based on inaccurate data.	F 514	F-514 Corrective Actions: Resident #1 will be assessed for signs and symptoms of leg edema and weeping. Pertinent findings will be reported to attending physician, orders noted, care plan updated and responsible party notified as applicable. Identification of other Residents Potentially Affected: The CNO/designee will conduct a skin sweep of the resident's currently residing in the Living Center to validate for appropriate treatment of leg edema. Any identified areas will be further assessed, responsible party and physician notified, physician orders noted and care plan updated with applicable interventions. Systemic Changes: 1. The CNO will provide further education to licensed nurses regarding documentation including assessments, care plans, and documentation on treatment record. 2. Telephone orders will be reviewed in the morning meeting (Stand-up Meeting). Orders will be reviewed for accuracy in how they are written and orders will be validated on the eMAR/eTAR.	5/15/15	

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F 514	<p>Continued From page 45</p> <p>Findings included:</p> <p>1. Resident #1 was admitted to the facility with multiple diagnoses including CHF, HTN, lower leg edema, A-fib, hypothyroidism, diabetes mellitus, pleural effusion, and muscle weakness.</p> <p>The resident's 1/21/15 admission MDS coded moderately impaired cognition, no pressure, venous or arterial ulcers, and the application of nonsurgical dressings other than to feet.</p> <p>The resident's 1/16/15 Resident Care Plan included an addendum: - 2/2/15, Due to 2+ edema and weeping in my lower legs, the wound care nurse has placed compression wraps on both of my lower legs to help bring the swelling down. They will remove these when the edema has resolved.</p> <p>The resident's medical record contained the following orders related to the resident's lower extremities. - Admissions Boarding Slip (admission orders) for TED Hose - 1/15/15 order for TED Hose see care tracker documented on the 2/15 Physician's Orders (recapitulation). - 1/15/15 PTOs, compression wraps to lower extremities bilateral prn per wound care. - 2/19/15 PTOs, discontinue TED hose related to non-use.</p> <p>The resident's 2/15 Treatment Sheet (TAR) contained the 1/15/15 order "TED Hose see care tracker" and an initialed, handwritten entry "dc'd [discontinued] 2/19/15." The TAR did not contain any documentation related to the use or non-use of TED Hose or compression wraps.</p>	F 514	<p>(F-514 Continued)</p> <p>Monitoring: The CNO/designee will conduct random record reviews/interviews 3 times a week to validate accurate documentation of skin assessment, that appropriate preventive measures have been implemented, that accurate documentation including assessments has been completed, that care plans have been updated, and orders are written correctly on the eMAR/eTAR. Quality Assurance and Performance Improvement Any concerns identified with above monitoring will be corrected and any trends identified will be reported to the Quality Assurance and Performance Committee as needed and monthly until a lesser frequency is deemed appropriate.</p>	

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F 514	Continued From page 46 Review of the resident's care tracker data revealed no data related to the resident's use or non-use of the TED hose or compression wraps. During an interview on 2/26/15 at 1:20 p.m., the Wound Nurse said the resident's use of TED Hose and compression wraps was not documented in the clinical record or in Care Tracker. On 2/26/15 at 5:25 p.m., the Administrator and the CNO were informed of the finding. The facility did not provide any additional information.	F 514			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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.	F 520	F-520 Corrective Actions: The CEO/designee will re-establish the Quality Assurance Performance Improvement Committee (QAPI) expectations to identify and resolve systemic problems. Identification of other Residents Potentially Affected: All residents are potentially affected Systemic changes: The CEO/designee will provide further education to the QAPI committee on the responsibility and requirements to identify and resolve systemic problems. This will include review of pertinent clinical/operational systems necessary to provide quality care to the residents residing in the Living Center. Identified trends will be placed on a four step action plan which will list concern, goal, action to be taken, date of completion goal and responsible party. The four step action plan will be reviewed as needed in an Ad Hoc QAPI committee meeting or monthly as applicable and revised until concern has been satisfactorily resolved. Monitoring: The CEO/designee will review and or participate in the monthly QAPI meeting to validate that	4/15/15	

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F 520	<p>Continued From page 47</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 observation, record review, staff interview and a review of the facility's compliance history, it was determined the facility's quality assessment and assurance committee failed to take actions that identified and resolved systematic problems for 10 of 10 sampled residents (Residents #1 - #10), with the potential to affect all residents in the facility. This failure resulted in the quality assessment and assurance committee providing insufficient direction and control over the facility necessary to ensure residents' needs were met. The findings include:</p> <p>1. The quality assessment and assurance committee failed to provide sufficient monitoring and oversight necessary to achieve and sustain regulatory compliance, as follows:</p> <p>a. The facility was previously cited at F520 during the annual recertification survey, dated 10/26/12.</p> <p>b. Refer to F167 as it relates to the quality assessment and assurance committee's failure to ensure prior survey results were readily accessible to residents. The facility was previously cited at F167, scope and severity C, during the annual recertification survey, dated 7/15/11.</p> <p>c. Refer to F225 as it relates to the quality assessment and assurance committee's failure to ensure residents were immediately protected and</p>	F 520	(F-520 continued) system review trends are strategically evaluated and action plans put into place and monitored routinely to resolve issues and sustain corrections. Any deficient practices will be corrected. Quality Assurance and Performance Improvement: The above monitoring will continue until deemed appropriate by the CEO.		

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F 520	<p>Continued From page 48</p> <p>a thorough investigation was completed for all allegations of abuse, neglect or mistreatment. The facility was previously cited at F225, scope and severity D, during the annual recertification survey, dated 7/15/11.</p> <p>d. Refer to F280 as it relates to the quality assessment and assurance committee's failure to ensure a care plan was developed for each resident for each assessed need. The facility was previously cited at F280, scope and severity D, during the annual recertification survey, dated 10/26/12.</p> <p>f. Refer to F309 as it relates to the quality assessment and assurance committee's failure to communicate with a resident's hospice provider. The facility was previously cited at F309, scope and severity D, during the annual recertification surveys, dated 12/6/13, 10/26/12 and 7/15/11.</p> <p>g. Refer to F314 as it relates to the quality assessment and assurance committee's failure to ensure residents did not develop pressure ulcers. The facility was previously cited at F314, scope and severity G, during the annual recertification survey, dated 7/15/11.</p> <p>h. Refer to F323 as it relates to the quality assessment and assurance committee's failure to ensure all possible precautions were implemented to ensure residents did not fall. The facility was previously cited at F323, scope and severity G, during the annual recertification surveys, dated 12/6/13 and 10/26/12. The facility was also previously cited at F323, scope and severity E, during the annual recertification survey, dated 7/15/11.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
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F 520	<p>Continued From page 49</p> <p>i. Refer to F328 as it relates to the quality assessment and assurance committee's failure to ensure a resident was provided with oxygen per physician's orders. The facility was previously cited at F328, scope and severity D, during the annual recertification surveys, dated 12/6/13 and 7/15/11.</p> <p>j. Refer to F329 as it relates to the the quality assessment and assurance committee's failure to ensure residents were only given medications with clear indications for their use. The facility was previously cited at F329, scope and severity D, during the annual recertification surveys, dated 12/6/13 and 10/26/12. The facility was also previously cited at F329, scope and severity E, during the annual recertification survey, dated 7/15/11.</p> <p>h. Refer to F431 as it relates to the quality assessment and assurance committee's failure to ensure out-dated medications were removed from the facility. The facility was previously cited at F431, scope and severity E, during the annual recertification survey, dated 7/15/11.</p> <p>i. Refer to F441 as it relates to the quality assessment and assurance committee's failure to ensure policies and procedures for the sanitation of podiatry equipment were developed and implemented. The facility was previously cited at F441, scope and severity E, during the annual recertification survey, dated 7/15/11.</p> <p>j. Refer to F514 as it relates to the quality assessment and assurance committee's failure to ensure resident records contained accurate and comprehensive documentation. The facility was previously cited at F514, scope and severity D,</p>	F 520			

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

PRINTED: 03/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2015
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83278		
(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 520	Continued From page 50 during the annual recertification surveys, dated 12/6/13 and 7/15/11. The quality assessment and assurance committee failed to take actions that identified and resolved systematic problems.	F 520			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

FILE COPY

August 10, 2015

Jon F. Smith, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Smith:

On **February 27, 2015**, an unannounced on-site complaint survey was conducted at Caribou Memorial Living Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey of February 23, 2015 to February 27, 2015.

The following observations were completed:

The dining and activity rooms were observed for cleanliness and adequate space.

Square footage per person for the activities room and dining room was reviewed by the survey team. No concerns with adequate space were noted at that time.

The facility's blueprints were reviewed and there were no changes to the two rooms previously reviewed by surveyors.

During a group interview, residents were interviewed regarding areas used for activities and dining, and housekeeping staff were interviewed regarding cleaning.

The complaint allegations, findings and conclusions are as follows:

Complaint #6558

ALLEGATION #1:

The complainant stated food is spilled on the carpet in the dining and activity room and spot cleaning does not keep the carpet clean.

FINDINGS #1:

The dining and activity rooms were observed for cleanliness and adequate space; no concerns were noted.

The resident group interview did not identify dirty carpet as a concern, and housekeeping staff said the carpet in the dining room was cleaned daily.

Based on record reviews and resident interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated residents were not provided with sufficient space for activities and dining.

FINDINGS #2:

Square footage per person for the activities room and dining room were reviewed by the survey team. No concerns with adequate space were noted at that time.

The facility's blueprints were also reviewed and there were no changes to the two rooms previously reviewed by surveyors.

Observations were conducted during the survey with no concerns for adequate space for either activities or dining.

During a group interview, residents stated they had no concerns with the areas used for activities and dining.

Based on record reviews and resident interviews, it was determined the allegation could not be

Jon F. Smith, Administrator
August 10, 2015
Page 3

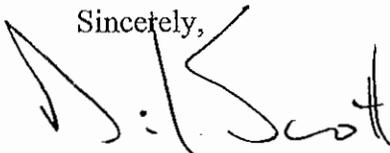
substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Scott". The signature is written in a cursive style with a large initial "D" and a long horizontal stroke.

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

DS/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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FILE COPY

August 10, 2015

Jon F. Smith, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Smith:

On **February 27, 2015**, an unannounced on-site complaint survey was conducted at Caribou Memorial Living Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey of February 23, 2015 to February 27, 2015.

The complaint allegations, findings and conclusions are as follows:

Complaint #6708

ALLEGATION #1:

The complainant stated residents were not provided with sufficient space for activities and dining.

FINDINGS #1:

Square footage per person for the activities room and dining room was reviewed by the survey team. No concerns with adequate space were noted at that time.

Observations conducted during the survey revealed no concerns with adequate space for either

Jon F. Smith, Administrator
August 10, 2015
Page 2

activities or dining.

During a group interview, residents stated they had no concerns with the areas used for activities and dining.

The facility's blueprints were reviewed. There were no changes to the two rooms previously reviewed by surveyors.

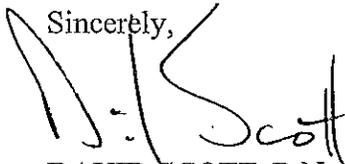
Based on record reviews and resident interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

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

DS/dmj