IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

March 12, 2015

Troy L. Thayne, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Thayne:

On **February 27, 2015**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Coeur d'Alene Health Care & Rehabilitation 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign 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 **March 25, 2015.** Failure to submit an acceptable PoC by **March 25, 2015,** may result in the imposition of civil monetary penalties by **April 14, 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; and
- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 3, 2015 (Opportunity to Correct).** Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 3, 2015.** A change in the seriousness of the deficiencies on **April 3, 2015,** may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 3, 2015** includes the following:

Denial of payment for new admissions effective **May 27, 2015.** [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **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 & 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, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 27, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

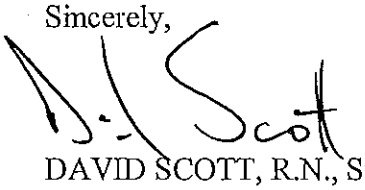
  2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **March 25, 2015**. If your request for informal dispute resolution is received after **March 25, 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,



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

DS/dmj
Enclosures

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

PRINTED: 03/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
	135052		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(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	INITIAL COMMENTS The following deficiencies were cited during the annual recertification, state licensure, and complaint investigation survey of your facility on 2/23/2015 through 2/27/2015. The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Sherri Case, LSW, QMRP Survey Definitions: ADL - Activities of Daily Living AROM - Active Range of Motion BID - twice daily BIMS - Brief Interview for Mental Status cm - Centimeters CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease DCS - Director of Clinical Services DON - Director of Nursing DNS - Director of Nursing Services LN - Licensed Nurse MAR - Medication Administration Record MDS -Minimum Data Assessment PO - By mouth PRN - As needed PROM - Passive Range of Motion QID - four times a day QOD - every other day TID - Three times a day W/C - Wheelchair	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. **This Plan of Correction will serve as the Facility's allegation of substantial compliance** **F 280** 1.) Resident #1's self care deficit, nutritional risk and restorative care plans have been updated to reflect resident's current status. Resident #2's skin breakdown care plan regarding geri-sleeves has been updated to reflect resident choice to wear geri-sleeves. 2.) An audit of current resident care plans has been completed to ensure their current status is communicated on the resident's plan of care which includes the kardex. The DCS/designee reads the comprehensive 24 report to the IDT at daily stand up meeting to ensure changes in condition are updated on the resident's plan of care and kardex.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		

RECEIVED
APR 17 2015
FACILITY STANDARDS

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

Administrator 4/14/15

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 280	Continued From page 1 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 2 of 10 (#s 1 & 2) sampled residents. This failure created the potential for confusion among staff in providing adaptive eating utensils, eating assistance, and RNA (Restorative Nursing Assistance) for Resident #1, and unnecessarily equipping Resident #2 with geri sleeves. Findings included: 1. Resident #1 was readmitted to the facility on 5/13/13 with multiple diagnoses, including encephalopathy, bipolar disorder, and hypertension (HTN). The resident's quarterly MDS assessment, dated 1/26/15, documented the resident's cognitive	F 280	3.) The clinical staff and IDT were re-inserviced on utilizing the comprehensive 24 report to communicate resident changes in the condition every shift. 4.) ED/designee will audit the comprehensive 24 hour report at the daily stand up meeting to ensure changes in condition are updated on the resident's care plan and kardex. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance x3 months. 5.) Compliance date: 3/30/15	

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F 280	Continued From page 2 level as being intact; extensive to total 1-2 staff assist for transferring, dressing, eating, toileting, and locomotion on the unit; bilateral upper extremity ROM (range of motion) functional impairment, and no lower extremity ROM functional impairment. The resident's February 2015 recapitulation Physician's Orders documented, *"...11/26/14 Skilled PT [Physical Therapy] for BLE [bilateral lower extremities] contractures to include: Manual therapy, There [Therapy] Ex/Act [exercise/activity]..." Resident #1's January and February 2015 Restorative Tracking Form documented, *"...PROM [passive range of motion] to fingers R [right] & L [left] hands...PROM to UE [upper extremities] and LE [lower extremities] bilateral...Restorative goals[:] 0 worsening contractures [and] prevent further contractures..." The tracking form documented the resident had participated daily 15 to 30 minutes for each of the 3 shifts. The total time per day varied from 45 to 60 minutes seven days per week. *"...Set up tray by cutting meat into bite size...cue to eat slowly...Restorative goals[:] Prevent choking [and] 0 significant weight loss..." The tracking form documented the resident had participated daily 40 minutes for each of the 3 meals. The total time per day varied from 110 to 120 minutes seven days per week. Resident #1's breakfast meal card, dated 2/25/15, documented, "...Adapt. Equip: Please cut up meats...Dining location: Ponderosa..." Resident #1's current Care Plan documented: *"Problem: Self Care deficit...Date	F 280		

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F 280	Continued From page 3 5/16/14...Interventions/Approaches: Locomotion: Total A [assistance], uses tilt in space w.c. [wheelchair] with foot cradle. Dressing Total A [assistance], prefers to be in hospital gown. Eating: Total A in MDR [main dining room]...date 6/11/14..." *"Problem: Nutritional Risk...Date 7/24/14...Interventions/Approaches: Encourage to get up for meals...Fluids in nosey cup." *"Problem: Contractures fingers (R/L hands)...Date 5/15/14...Interventions/Approaches: PROM to fingers (R/L hands) 15 minutes per day, 6/7 days per week." On 2/23/15 at 12:15 PM, 2/24/15 at 8:10 AM and 11:45 AM, and 2/25/15 at 8:30 AM, during meal observations, staff were observed to wheel Resident #1 in a wheelchair into the main dining room. The resident was seated in a wheelchair with foot cradles and placed at the restorative dining table. Resident #1 was dressed and groomed appropriately. The resident ate breakfast and lunch meals independently after setup, with a staff member close by who assisted with cues. Resident #1 was observed to have no adaptive dining equipment and used regular glasses and cups for the fluids. On 2/25/15 at 9:04 AM, CNA #3 was interviewed regarding Resident #1's RNA program for dining and the PROM for her hands. The CNA said the resident ate independently after she was setup. The staff would assist with cutting up the resident's meat and stay close to cue her to chew, then swallow before she took the next bite. CNA #3 stated the resident's range of motion program consisted of 15 minutes per shift (11 PM -7 AM, 7 AM -3 PM, and 3 PM -11 PM) for PROM for bilateral hands, as well as AROM for bilateral	F 280		

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F 280	Continued From page 4 upper and lower extremities. The CNA stated the resident was actively participating with Physical Therapy for the lower extremities, rode a bike, and had recently begun to walk with PT assistance. On 2/26/15 at 11:05 AM, the DCS stated the resident was not a "total assist and she's independent with eating and she eats in the main dining room." The DCS stated the resident was their "star pupil," having progressed from being on hospice to the prospect of being able to return to the community. The DCS stated the resident's Care Plan needed to be updated to reflect the resident's improved status. The resident did not use or need a nosey cup, ate independently with staff supervision and cuing as necessary, preferred a hospital gown only for night, and the RNA program included Resident #1's bilateral hands, and upper and lower extremities. On 2/26/15 at 5:45 PM, the Administrator and DCS were informed of the Care Plan concerns. There was no additional documentation provided to alleviate the issues. 2. Resident #2 was admitted to the facility on 11/13/12 with diagnoses which included diabetes and dementia with behaviors. The resident's Care Plan for skin breakdown included an intervention for long sleeves or geri-sleeves with a start date of 11/28/14. The resident's 2/1/15 Physician's Orders included and order for geri-sleeves at all times, which had a line drawn through it, and documented it had been discontinued on 1/30/15.	F 280		

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F 280	Continued From page 5 During observations on 2/23/15 at 12:30 p.m., 2/24/15 at 8:00 a.m., and 2/25/15 at 7:20 a.m. and 11:45 a.m., the resident was observed wearing the geri-sleeves. On 2/26/15 at 3:00 p.m., the DCS was asked about the care plan intervention to wear geri sleeves. The DCS stated the care plan should have been revised to allow the resident to choose if she wanted to wear the geri-sleeves.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and the facility's Insulin Injections Policies and Procedures, it was determined the facility failed to ensure professional standards of quality of care were maintained. This was true for 1 of 9 residents reviewed for blood glucose levels (Resident #2) and 1 of 4 random residents (#11) observed during the medication pass observations. This failure created the potential for harm should residents not receive cleansing of an injection site for microorganisms prior to a subcutaneous insulin injection. Findings included: 1. Resident #11 was admitted to the facility on 1/14/15 with multiple diagnoses including Diabetes Mellitus, chronic renal failure, and bipolar.	F 281	**F 281** 1. LN #2 was immediately re-educated on the proper procedure for administering injections. Resident 2's diabetic medication record (DMR) has been revised to accurately reflect blood glucose (BG) levels and intervention if below 70 per physician order. 2. Current diabetic residents Diabetic Medication Record (DMR) were audited to ensure documentation accurately reflects the blood glucose level with interventions when blood glucose falls below 70. 3. Licensed Nurses have been in-serviced and competency tested on proper procedure for administering injections and documentation of interventions for blood glucose parameters per physician order.	

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F 281	Continued From page 6 The resident's February 2015 recapitulation Physician Orders and MAR documented, "...1/14/15 FSBG [fasting sugar blood glucose] before meals and at bedtime...Humalog 100 Units/ML...Humalog Sliding Scale 151-200=5 units 201-250=10 units 251-300=15 units..." On 2/24/15 at 11:40 AM, the resident had a FSBG of 213 and LN #2 prepared an insulin syringe with 10 units of Humalog for administration. LN #2 went into the resident's room, pulled the privacy curtain, washed her hands, donned gloved, had the resident pull up his shirt, and she handed him a kleenex. The LN had an unwrapped alcohol swab in her hand, took the cap off the insulin syringe, and then proceeded to administer the injection into the resident's right abdomen. The resident had a very small amount of blood seep from the injection site which he wiped off and the LN tore the alcohol swab open and then pressed and held the swab against the site for a few seconds. On 2/24/15 at 11:45 AM, the surveyor asked LN #2 about her procedure of cleansing an injection site. LN #2 stated, "He says the alcohol stings and he doesn't want you to use it first." The LN said she remembered being told not to use the alcohol by another staff member and hadn't actually discussed the proper technique or the risks and benefits to the resident. LN #2 said the resident was capable of checking his own BGs (blood glucose) and administering his own insulin injections, but he had very poor hygiene and so nursing staff had continued to perform these tasks. On 2/24/15 at 12:16 PM, Resident #11 was asked about his insulin injections. He reported he was	F 281	4. DCS/designee will conduct an observation audit of licensed nurses administering injections twice a week x 4 weeks, then monthly x 2 months to ensure injections are given per policy. The DCS/designee will audit the DMR to ensure blood glucose documentation accurately reflects interventions per physician orders weekly x 4 weeks, then monthly x 2 months. Results of the audits will be reported to the monthly QAPI committee to ensure substantial compliance x 3 months. 5. Compliance date 3/30/15	

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F 281	Continued From page 7 capable of checking his blood glucose and administering his insulin, but he preferred the nurses performed these tasks. The resident said the nurses "always" use an alcohol swab first and next administer the insulin. The resident said he had received insulin for a long time and the alcohol did not sting or burn. Clinical Nursing Skills & Techniques, 8th edition, 2014, by Perry, Potter, and Ostendorf, pages 559, state, "...8 Select appropriate injection site. 9 Palpate sites and avoid those with masses or tenderness...10 Help patient into comfortable position...11 Relocate site using anatomic landmarks...12 Clean site with antiseptic swab. Apply swab at center of site and rotate outward in circular direction for about 5 cm (2 inches)...Mechanical action of swab removes secretions containing microorganisms." The facility provided its Insulin Injections Policies and Procedures on 2/26/15, with an effective date of 11/30/14. The Policies and Procedures documented, *"...Cleanse the area where the injection is to be made with an alcohol pad...stabilize the skin by spreading it or pinching up a large area of skin...Insert the needle straight into the skin...push the plunger all the way down...Hold an alcohol swab near the needle and pull the needle straight out of the skin. Press alcohol swab over the injection site for several seconds..." On 2/26/15 at 5:45 PM, the Administrator and DCS were informed of the concern. No additional documentation was provided to resolve the issue. 2. Resident #2 was admitted to the facility on 11/13/12 with diagnoses which included diabetes	F 281		

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F 281	Continued From page 8 and dementia with behaviors. The Physician Order Report (recapitulation orders) for February 2015 documented orders for BG checks before breakfast and dinner. If FSBG (fasting blood sugar checks) were less than 70 mg/dl, staff were to give sugar/juice and recheck in 15 minutes. The orders directed staff to repeat sugar/juice until BGs rose above 70 mg/dl. Start date of 1/1/13. NOTE: The American Diabetes Association recommends a fasting blood glucose (BG) target range of 70-130 mg/dl [milligrams per decaliter]. The resident's diabetes care plan included an intervention to check the resident's blood sugar levels twice daily with a start date of 9/19/14. Review of the resident's December 2014 Diabetic Medication Record (DMR) for for 12/5/14 revealed that at 6:00 a.m. staff did not document a BG check. BG checks at 6:00 a.m. on 12/9/14 documented a BG of 62 and on 12/29/15 the BG was a documented 69. The section to document the resident received sugar/juice and that the BG was rechecked after 15 minutes was blank. Review of the resident's January 2015 DMR on 1/1/15 at 6:00 a.m. revealed a BG of 65. The form did not document the resident received sugar/ juice or a recheck of the BG . On 1/4/15 the resident's BG was documented as 58, the resident received medpass and the BG was rechecked in 30 minutes. On 1/15/15 the BG level was documented as 53 and, with a recheck of 109. On 1/23/15, the resident's BG level was documented as 60, with a recheck of 148. The form did not document interventions or when the	F 281		

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F 281	Continued From page 9 recheck was completed. The resident's February 2015 DMR documented on 2/815 at 6:00 a.m. a BG of 54. The form did not document the resident received sugar/juice or a recheck of the BG. On 2/26/15 at 9:15 a.m., the DCS was informed the BG was not documented on 1/5/15, and the interventions, as well as the 15 minute recheck for the above low BG levels, were not documented. The DCS was informed the nurses notes did not document the interventions or rechecks for the dates of concern. When asked if the recheck after 30 minutes documented on 1/14/15 was acceptable, the DCS stated it should have been done within 15 minutes of the intervention. The DCS stated she would provide additional information at a later time. On 2/26/15 at 11:00 a.m., the facility provided documentation the resident was seen by the physician on 12/4/14, 12/20/14, 1/3/15, and 1/11/15, and that he/she was aware of the low BGs and had reviewed and adjusted the resident's diabetes medications. The resident was also seen by the physician on 1/23/15 and 2/9/15. On 2/9/15, the physician ordered a protein snack at bedtime "to help with stabilizing a.m. blood sugars...".	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	**F309** 1. Resident #1's medication record has been revised to accurately reflect vital sign parameters per physician orders. 2. Medication administration records (MAR) of current residents receiving medications requiring vital sign monitoring prior to administration have been audited to ensure vital signs are documented on the MAR. 3. Licensed nurses have been in-serviced on obtaining vital signs prior to administration of cardiac medication per physician order and documenting results on the MAR.	

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F 309	Continued From page 10 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to follow physician orders to check a resident's heart rate prior to administering cardiac medication (Resident #1). This had the potential for an adverse reaction if the resident's heart rate was outside the parameter for administration of the medication. Findings included: Resident #1 was readmitted to the facility on 5/13/13 with multiple diagnoses, including encephalopathy, bipolar disorder, and hypertension (HTN). Resident #1's current Care Plan documented: *Problem: Cardiovascular: Potential for high blood pressure (BP) related to diagnosis of HTN. Dated 5/15/14. *Goal: Will maintain stable BP, pulse rate, rhythm and respiratory parameters within baseline levels through next review date. *Interventions/Approaches: Notify physician of BP changes and out of normal range. Administer Rx as scheduled. VS (vital signs) with parameters for holding Rx. The resident's February 2015 recapitulation Physician's Orders documented, "...12/24/14 Metoprolol Tartrate 50 mg tab [tablet]: Give 1 tablet orally 2 times a day; Hold if SBP [systolic blood pressure] less than 100 or HR [heart rate] less than 55 (HTN)..."	F 309	4. DCS/designee will observe medication administration for residents receiving cardiac medications twice a week to ensure vital signs are monitored in accordance with physician orders x 4 weeks, then monthly x 2 months. The DCS/designee will audit MAR documentation to ensure vital signs are documented per physician orders weekly x 4 weeks, then monthly x 2 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5 Compliance date 3/30/15	

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NAME OF PROVIDER OR SUPPLIER: COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER

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F 309	Continued From page 11 Resident #1's February 2015 MAR (Medication Administration Record) documented, "...Metoprolol Tartrate 50 mg tab 12/24/14...Give 1 tablet orally 2 times a day; hold if SBP less than 100 or HR less than 55..." The MAR contained documentation the resident had been administered the Metoprolol Tartrate and her BP was recorded twice a day, at 8:00 AM and 4:00 PM, on 2/1 through 2/24/15. Resident #1's MAR did not document the HR was monitored on 44 different occasions prior to the Metoprolol Tartrate being administered in February. On 2/27/15 at 11:15 AM, the DCS stated in regards to the resident's physician order of holding the Metoprolol for a heart rate of less than 55, "There's parameters for her. Yes, her heart rate should have been checked." The DCS said she would check if there was any additional documentation that could be provided. No additional information was provided to alleviate the concern.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration	F 322	**F322** 1.) Licensed Nurse #1 was immediately re-educated on proper procedure for administering medications via PEG tube. 2.) An observation audit of current the resident with a PEG tube has been completed to ensure licensed nurses are following policy/procedure when administering medications, which includes checking placement. 3.) Licensed Nurses were in-serviced and competency tested on medication administration via PEG tube to include checking placement.	

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F 322	Continued From page 12 pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure there was correct placement of a PEG (percutaneous endoscopic gastrostomy) tube prior to the administration of medications and did not allow the medication to be administered by gravity flow. This affected 1 of 2 residents (#7) during PEG medication pass observations. This failure created the potential for the resident to experience gastrointestinal distress and/or aspiration and not receive the optimal benefit of pain medication that was administered. Findings included: Resident #7 was readmitted to the facility on 10/9/12 with multiple diagnoses including cerebrovascular accident, dysphagia, encephalopathy, pneumonia, and chronic respiratory failure. The resident's February 2015 recapitulation Physician's Orders and MAR documented, "...1/21/15 Hydrocodone-Acetaminophen 5-325 mg...Give 1 tablet via tube 3 times a day..." and "...Flush tube with 30 ml water before and after medications..."	F 322	4.) DCS/designee will observe medication administration via PEG tube twice a week to ensure Licensed Nurses are following policy/procedure, to include checking tube placement, prior to administration of medication x 4 weeks, then monthly x 2 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5.) Compliance date 3/30/15	

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F 322	Continued From page 13 On 2/24/15 at 3:35 PM, LN #1 was observed administering 1 crushed Hydrocodone-APAP 5/325 mg mixed with water. The LN drew up the crushed medication and water into a syringe, attached the syringe to the PEG tube, pushed the solution into Resident #7's PEG tube, drew up in the syringe the remaining water, and then pushed the remaining water into the PEG. LN #1 stated she had administered approximately 70 ml of water and then flushed with another 30 mls. The LN did not check for PEG placement prior to the administration of the medication and water or allow the medication and water to be administered via gravity flow.. When the LN was asked about when and how she checked for PEG placement she stated, "I didn't." The LN acknowledged that she is to check for PEG placement prior to the administration of any feedings or medications and failed to do so with the resident. LN #1 stated, "I listen with a stethoscope and push in 20 ml of air." The facility provided their Medication-Administration Via Enteral Tube Policies and Procedures on 2/26/15, with an effective date of 11/30/14 . The Policies and Procedures documented, *"...Checking for placement of enteral tube...attach syringe to end of tube and place stethoscope over left upper quadrant of the resident's abdomen. Instill approximately 20 cc (cubic centimeters) of air using the syringe while listening for a "swooshing" sound in the stomach...and/or... Aspirate by gently pulling back on plunger of syringe to check for stomach contents..." *After checking for placement, remove the syringe and then remove the plunger from the syringe...Pour at least 15 cc of clear liquid into the	F 322		

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F 322	Continued From page 14 syringe and allow to drain into tube prior to medication administration... Pour one, individual liquefied medication in the syringe, and allow gravity to drain medication into the stomach. Followed by at least 15 cc (or physician order if different) of water in between each medication..." *...When finished administering the medication, follow with at least 15 cc of clear liquid to flush the tube..." On 2/26/15 at 5:45 PM, the Administrator and the DCS were informed of the concern. No additional documentation was provided to resolve the issue.	F 322		
F 329 D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any 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.	F 329	F329 1. Residents #2 and #6's care plans were reviewed and updated to reflect how their behaviors are exhibited, which behaviors to monitor and specific interventions to manage the behaviors. Interventions will include resident strengths and coping skills. 2. Current residents receiving medications for depression, schizophrenia and anxiety were audited to ensure care plans address specific behaviors with interventions to manage those behaviors. Behavior management meeting is conducted weekly to review resident behaviors, interventions, documentation and care plans. 3. The IDT was in-serviced on the Behavior Management policy/procedure to include	

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F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure behaviors were adequately monitored for the use of medications for the treatment of schizophrenia, depression and anxiety. This was true for 2 of 6 (#s 2 and 6) sampled residents reviewed for unnecessary medications. This failed practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included: 1. Resident #6 was admitted to the facility on 9/8/09 with diagnoses which included anxiety, schizophrenia, and macular degeneration. The resident's 2/1/15 Physician's Orders (recapitulation) included: *Fluoxetine (Prozac - antidepressant) 10 mg daily for depression with a start date of 6/8/13. *Lorazepam (Ativan - anxiolytic) 0.5 mg daily for anxiety and 0.5 mg as needed both with a start date of 11/10/14 *Olanzapine (Zprexa - antipsychotic) 7.5 mg daily for schizophrenia with a start date of 6/18/13. The resident's July 2014 care plan for Depression included interventions to administer medication, observe for complaints of depression, side effects of the medication, behavior monitoring, support the resident's strengths and coping skills, allow open expression of feelings, and reinforce appropriate expression of feeling.	F 329	monitoring, documentation, and care plan development. The IDT will identify residents requiring behavior monitoring by diagnosis, use of psychoactive medications, and observation of specific behaviors. 4. DCS/designee will audit the Behavior Symptom Monitoring flow record and care plans to ensure specific behaviors and interventions are addressed for residents receiving psychoactive medications, during the weekly Behavior Management team meeting. Results of the audit will be reported the monthly QAPI committee x 3 months to ensure substantial compliance. 5. Compliance date 3/30/15.	

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F 329	Continued From page 16 The care plan did not include how the behaviors were exhibited or what behaviors to monitor (tearfulness, isolation, etc). How to support the strengths, or what the strengths or coping skills were, was not defined in the care plan, nor was there a definition of "open expression of feelings." The resident's 7/25/14 care plan for the use of antipsychotic medication included interventions to administer the medication, observe for side effects, approach calmly, monitor for behaviors, redirect when behaviors occur and provide positive feedback when resident is compliant and appropriate. The care plan did not include what behaviors to monitor (hallucinations, delusions, apathy, etc.), how to redirect (activity, talk about family, etc.) or define compliant and appropriate. The resident's 7/26/14 care plan for anxiety included interventions of behavior monitoring and attempt non-pharmacological interventions prior to administering the as-needed medication. The care plan did not document how the behaviors were exhibited or what the non-pharmacological interventions. The January 2015 and February 2015 Behavior Symptom Monitoring Flow Record (BSM) had behaviors listed restlessness, repetitive concerns, taking things from others and physical harm to self. The cause/trigger section identified worries in section "A" and non-pharmacological interventions documented staff were to allow the resident to voice concerns, redirect the resident to activities, and provide reassurance. The Pharmacological intervention section documented Zyprexa, Ativan and Prozac.	F 329		

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F 329	Continued From page 17 The BSM identified behaviors, but did not include if the behaviors were demonstrated when the resident was depressed, anxious or if worry was the trigger for all behaviors. Additionally the BSM did not include how the behaviors of restlessness, repetitive concerns and physical harm to self were exhibited. Without specific behaviors or interventions it would not be possible to accurately monitor and document the signs and symptoms of depression, schizophrenia, anxiety or the effectiveness of the interventions. On 2/26/15 at 12:00 p.m., the DCS stated Zyprexa was ordered in response to the resident biting her fingers and for repetitive conversations about "her funeral." The DCS stated the resident's depressive behaviors were exhibited when the resident would isolate in her room, shut the door and turn off the lights. The DCS stated the resident's propensity for physical harm to self on the BSM was exhibited when she bit her fingers. The DCS stated the resident's intervention for redirection needed to specify talkingt with the resident about jewelry or the hairdresser and "appropriate" meant the resident displayed a positive attitude. The DCS stated there were no non-pharmacological interventions included on the resident's care plan for anxiety. 2. Resident #2 was admitted to the facility on 11/13/12 with diagnoses which included diabetes and dementia with behaviors. The resident's 2/1/15 recapitulation Physician's Orders included an order for Mirtazapine (antidepressant) 7.5 mg daily for depression with	F 329		

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F 329	Continued From page 18 a start date of 10/21/14. The resident's care plan for "Altered Psychosocial Well-Being" interventions included encouraging the resident to attend activities, verbalize feelings, family visits, and talking with the resident regarding likes/dislikes, and to express his/her feelings. The interventions did not include favorite activities, likes/dislikes, or how to encourage the resident to verbalize feelings. Additionally, the care plan did not include frequency of depression, duration of the depression, what triggered the depression or what the resident was trying to communicate. Without specific interventions it would not be possible to evaluate the consistency of the interventions to reduce the incidents of depression. The Decembrer 2014 and January 2015 BSM documented behaviors of physical aggression and a trigger of attempts to participate in activities of daily living. The BSM identified the antidepressant medication and interventions of redirection, reassurance, toileting, and returning to room. The 2/15 BSM included the same information, but included a behavior of stripping off clothing in the halls. On 2/26/15 at 12:00 p.m. the DCS acknowledged it would not be possible to monitor the need for the medication without resident specific behaviors or interventions in the care plan. When asked about the behavior of stripping in the hall on the February 2015 BSM, the DCS stated the resident had a UTI, which accounted for this behavior.	F 329		

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F 329	Continued From page 19 On 2/27/15 at 11:45 a.m., the Administrator and the DCS were informed of the above concerns. The facility provided no further information.	F 329	monitoring, documentation, and care plan development. The IDT will identify residents requiring behavior monitoring by diagnosis, use of psychoactive medications, and observation of specific behaviors.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident group interview, test tray evaluation, and staff interview, it was determined the facility failed to prepare palatable food. This affected 6 of 10 residents who attended the resident group interview and Random Resident #12. This had the potential to affect any resident who dined in the facility. This failure created the potential for a negative effect on residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included: On 2/24/15 at 2:00 p.m., two surveyors met with a group of 10 residents. When asked if hot foods were hot, 6 of the 10 residents stated the food was cold. Residents stated by the time the trays were delivered to their rooms the food was "not even warm." The residents stated the eggs were "always" cold. On 2/25/15 at about 8:00 a.m., the breakfast trays were observed being placed on a cart and the Dietary Manager (DM) was asked to put a test	F 364	4. DCS/designee will audit the Behavior Symptom Monitoring flow record and care plans to ensure specific behaviors and interventions are addressed for residents receiving psychoactive medications, during the weekly Behavior Management team meeting. Results of the audit will be reported the monthly QAPI committee x 3 months to ensure substantial compliance. 5. Compliance date 3/30/15.	

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COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

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F 364	Continued From page 20 tray on the cart for the surveyors. The surveyor observed as the trays were delivered to the residents, the last tray was received at 8:18 a.m. by the surveyors and the Dietary Manager. The test tray included oatmeal, eggs, bacon and a muffin. The DM and 2 surveyors evaluated the meal tray and determined the following: * oatmeal = 149.7 degrees Fahrenheit (F), flavor and temperature satisfactory; * bacon = unable to take temperature but taste and flavor satisfactory; * muffin = flavor satisfactory * eggs = 126.0 F; cool, barely warm, bland and rubbery. Upon completion of the test tray evaluation, the DM stated the eggs were, "bland, lukewarm." After the test tray was completed on 2/25/15 at 8:30 a.m., Random Resident #12 was observed in the dining room with his breakfast. The resident had not eaten his eggs and when ask why, he stated because they were "rubbery and cold ." On 2/26/15 at 5:45 PM, the Administrator and DCS were informed of the above concern. The facility provided no additional information.	F 364	**F364** 1. A new steamer has been purchased that will maintain food temperature and texture. 2. Hall trays will be prepared first utilizing the pellet system to maintain food temperature. Hall trays will be delivered to resident rooms promptly to ensure food is not cold or rubbery and is palatable. Residents who eat in the dining room will be served restaurant style to facilitate palatable food delivery. Residents will be offered alternatives when food is not satisfactory to their taste. 3. The Executive Director met with resident council to explain the new dining room service process and announce purchase of steamer that will improve food palatability. Facility staff was in-serviced on hall tray delivery and restaurant style delivery method in the dining room.	
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.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
	135052		02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2614 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

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F 514	Continued From page 21 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 residents' medical records were complete. This was true for 2 of 10 (#s 1 & 5) sampled residents, who received medications without documented diagnoses or indications for use. This failure created the potential for medical decisions to be based on incomplete information. Findings included: 1. Resident #1 was admitted to the facility on 5/13/13 with multiple diagnoses including encephalopathy, Parkinson's Disease, and Stage IV pressure ulcer. The resident's February 2015 recapitulation Physician Orders and MAR documented, "...12/31/14 Doxycycline Hyclate 100 mg [milligram] cap [capsule]...Give 1 capsule orally 2 times [X] a day X 10 days..." and "...1/29/15 Gabapentin [brand name: Neurontin] 200 mg PO [by mouth] BID [twice a day]..." The medication orders did not have diagnoses or indications for their use. Resident #1's Physician Orders, dated 12/19/14, documented the administration of Neurontin with a diagnosis of Parkinson's disease. The	F 514	4. The Mock survey team members will query residents during daily rounds to ensure food satisfaction. Concerns will be reported promptly for resolution. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. Compliance date 3/30/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
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COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

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F 514	Continued From page 22 resident's Physician Orders, dated 1/29/15, documented the Neurontin with a diagnosis of pain. The resident's Physician Orders, dated 12/31/14, documented the Doxycycline with a diagnosis of infection prevention. On 2/26/15 at 11:05 AM, the DCS was interviewed regarding the missing diagnoses for Resident #1's Doxycycline Hyclate and Gabapentin. The DCS acknowledged the diagnoses or indications for use were not documented and should be on the current recapitulated physician orders and MAR. 2. Resident #5 was admitted to the facility on 2/11/13 with multiple diagnoses including Rheumatoid Arthritis, chronic pain, and dementia. The resident's February 2015 recapitulation Physician Orders and MAR documented, "...1/12/15 Magnesium Supplement 400 mg one tab PO daily..." The medication order did not have a diagnosis or an indication for its use. Resident #5's Physician Order, dated 1/12/15, documented the Magnesium Supplement with a diagnosis of constipation. On 2/26/15 at 11:05 AM, the DCS was interviewed regarding the missing diagnoses for Resident #5's Magnesium Supplement. The DCS acknowledged the diagnosis or indication for use was not documented and should be on the current recapitulated physician orders and MAR. The DCS stated she would obtain clarification on the Magnesium Supplement, as she thought it was for the resident's Rheumatoid Arthritis and had not seen a diagnosis of use documented as	F 514	**F514** 1. Residents #1 and #5's Physician orders (POS) and MAR's were updated with an appropriate diagnosis for ordered medications. 2. Current resident Physician Orders sheets and MARs were audited to ensure medications have appropriate diagnosis. New orders are reviewed daily, five days a week, by the clinical manager to ensure medications have an appropriate diagnosis. 3. Licensed Nurses have been in-serviced on writing medication orders to include an appropriate diagnosis. 4. DCS/designee will review medication orders during daily clinical meetings to ensure medications have appropriate diagnoses. Results of the audit will be reported the monthly QAPI committee x 3 months to ensure substantial compliance. 5 - Compliance date 3/30/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
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F 514	Continued From page 23 constipation. On 2/26/15 at 5:45 PM, the Administrator and the DCS were informed of the concerns. No additional documentation was provided.	F 514		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
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MY COPY

April 7, 2015

Troy L. Thayne, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Thayne:

On **February 27, 2015**, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6865

ALLEGATION:

The reporting party stated a resident, who was a patient in the hospital for one night, was discharged from the facility and not allowed to return to the facility without a 30-day notification.

FINDINGS:

The allegation was investigated from February 23, 2015 through February 27, 2015, during the facility's Recertification and State Licensure survey. The following was completed during the investigation of the complaint:

Interviews were conducted with the Social Worker, Administrator and residents.

The facility's policy for discharge procedures was reviewed. Resident interdisciplinary notes, physician's orders and visit notes, behavior monitors and care plans were reviewed.

The facility's policy for an emergency discharge from the facility documented, the resident could

be discharged if the safety of individuals in the facility were endangered.

The identified resident's Interdisciplinary Progress Notes documented that on January 24, 2015, the resident was to be in-line of sight when out of bed due to lack of safety awareness and checked every 30 minutes while in bed. The following morning at 3:00 a.m., the resident was "panicked and anxious," yelling loudly and refused all medication. The resident's family member expressed concern, and the resident's physician ordered a medication injection for the safety of the resident or "others." The notes documented on January 26, 2015, at 3:30 p.m. that the resident threw a pitcher of water from the nurses' cart down the hall.

A January 29, 2015 note documented the resident threw items and was then placed on line-of-sight for safety reasons. A communication form to the physician included in the notes, dated January 29, 2015, the resident's behaviors "have escalated over past 12 hours." The communication form documented the resident placed himself on the floor, was crawling around, combative, verbally abusive and refused all medication. The form also documented the resident was a danger to himself and others due to uncontrolled behaviors. The resident was taken to the local hospital for an evaluation on January 29, 2015 at 2:30 a.m., but returned to the facility at 1:00 p.m.

On January 30, 2015 at 3:00 p.m., the resident refused his medication and threw his oral medications along with a cup of water. On January 31, 2015, the notes documented that during night shift the resident took off his briefs and walked into other residents' rooms. The resident kicked and hit staff when they attempted to redirect him from going into other residents' rooms. At 3:30 p.m. on January 31, 2015, the resident was documented as "throwing anything he can get (his) hands on."

The notes further documented that on February 2, 2015, the resident called 911 and police arrived. Due to the resident's aggressive behavior, police remained at the facility until a family member arrived. At 1:45 p.m. that day the notes documented the resident left the facility and was agitated when he returned. The facility provided one-to-one supervision and the physician increased the amount of an as-needed anti-anxiety medication. On February 3, 2015, the resident was agitated and again required one-to-one supervision, refused his medication and attempted to crawl out the front door. On February 4, 2015, the resident kicked a family member and refused his medication. The February 4, 2015, notes documented the resident was transported by a family member to a hospital in a nearby state.

A social worker late entry for February 5, 2015, documented that due to an increase in the resident's behaviors, an alternate placement for the resident needed to be found. The social worker informed the resident's family member of facilities better equipped to address residents with behaviors. The family member informed the social worker that the family member would transport the resident to a nearby hospital to be evaluated. At 1:30 p.m., the social worker spoke by phone to the family member (at the hospital,) who stated the plans were to have the resident

transferred to a geriatric psych program in Utah.

Surveyors were informed that another resident at the facility stated he was about to be discharged from the facility against his will. The Administrator was asked about this concern and stated the facility had discussed discharging the resident due to his behaviors of sexually inappropriate behavior with staff. However, the policy for discharge was reviewed and it was determined the behaviors did not meet the criteria for discharge and the resident would remain at the facility.

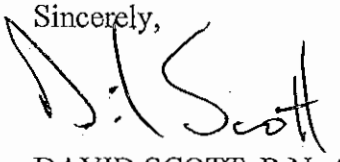
The social worker stated the resident's behaviors were escalating, which caused other residents to be fearful. The social worker stated a family member was informed of behavior facilities in the state, but the family wanted the resident to be transferred to another state where he would be closer to family. A family member came to the facility and transported the resident to the hospital to be evaluated. The family member was upset when the resident did not recognize him/her, stated this had never happened before and the resident was definitely going to the hospital.

The Administrator stated the resident had an increase in behaviors that could be harmful to the resident or other residents; started throwing things, such as a plate and a can of soda, which could have hit another resident in the dining room; and had kicked a family member who he/she had not been aggressive toward in the past. The Administrator stated the family member had been very upset when this happened and decided to take the resident to the hospital for an evaluation. The Administrator stated a physician from the hospital called the facility regarding the resident and was informed the resident's anger was directed at staff, but any resident nearby could have been injured when the resident threw items. The Administrator noted the family member was aware the facility could not meet the resident's needs and decided to take the resident to the hospital. The Administrator met the family member at the hospital and provided the letter of emergency discharge to the family member.

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,



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

DS/dmj