

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 26, 2015

Arthur F. Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

Dear Mr. Gulden:

On **March 13, 2015**, a Recertification and State Licensure survey was conducted at Bingham Memorial Skilled Nursing & Rehabilitation 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." **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.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 8, 2015**. Failure to submit an acceptable PoC by **April 8, 2015**, may result in the imposition of civil monetary penalties by **April 28, 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 the federal survey report, Form CMS-2567.

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 17, 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 17, 2015**. A change in the seriousness of the deficiencies on **April 17, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 17, 2015** includes the following:

Denial of payment for new admissions effective **June 13, 2015**. [42 CFR §488.417(a)]

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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 **September 13, 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 **March 13, 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

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2001-10 IDR Request Form

This request must be received by **April 8, 2015**. If your request for informal dispute resolution is received after **April 8, 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,

A handwritten signature in cursive script, appearing to read "Nina Sanderson".

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

NS/dmj
Enclosures

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

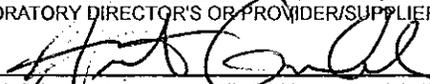
PRINTED: 03/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility. The survey team entered the facility March 9, 2015 and exited March 13, 2015.</p> <p>The survey team included Sherri Casey, BSW, LSW, QIDP, Team Coordinator and Arnold Rosling RN, QIDP.</p> <p>Definitions: MDS = Minimum Data Set assessment CAA = Care Area Assessment DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide e-MAR = electronic-Medication Administration Record mg = milligrams</p>	F 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p>	
F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is</p>	F 156	<p>F 156</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Re-issued the Medicare non-covered notice to resident 12's responsible party with specific reasoning included on the form.</p> <p>Resident 13 discharged from the facility prior to survey</p>	<p>RECEIVED APR - 8 2015 FACILITY STANDARDS</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/7/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone</p>	F 156	<p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents covered by Medicare or Medicare Advantage Plans may be affected.</p> <p>Business Office Manager to ensure Medicare non-covered notices have specific reasoning written on the notice and presented to patient and/or responsible party when issued.</p> <p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Root cause of the deficiency is that the Business Office Manager didn't know that the specific reasoning for non-coverage needed to be included in the notice.</p> <p>In-service will be given on or before April 17, 2015 to Business Office, Admissions, and Social Worker by the Administrator on F-156 regarding proper issuance of non-coverage notices.</p> <p>Each Medicare non-coverage notice will be discussed by IDT prior to issuance to ensure specific reason for non-coverage is written on the notice.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Administrator or designee will audit all Medicare non-coverage notices weekly for the period of at least 12 weeks beginning the week of April 12, 2015 to ensure specific reasoning is included on the form. Any issues noted will be addressed and fixed immediately.</p>	
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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F 156	<p>Continued From page 2</p> <p>numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and demand billing document review, it was determined the facility failed to provide an explanation to residents as to why they were no longer eligible for Medicare treatment coverage. This was true for 2 of 4 (#s 12 & 13) residents reviewed whose Medicare benefit no longer covered their treatment and services at the facility. There was a potential for psychological harm when a resident was not informed of changes in their Medicare entitlements. Findings include:</p>	F 156	<p>The QA committee will review the results of the audits and make a determination related to changing the frequency of those audits after the initial 12 weeks.</p>	4/17/15	

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F 156	Continued From page 3 1. Resident #12 was admitted to the facility on 2/4/15 for therapy. The resident's Medicare coverage ended on 3/6/15. The letter the resident received indicating he/she was no longer eligible for Medicare failed to give a reason why his/her benefits were stopped. 2. Resident #13 was admitted to the facility on 12/16/14 for therapy. The resident had a Medicare Advantage Plan. The resident's plan informed the facility it would no longer pay for the resident's stay. This information was not included in the letter the facility gave to the resident on 2/25/15. The business office manager was interviewed on 3/10/15 at 11:30 am. The Administrator and DON were interviewed at 6:30 p.m., and stated the facility will start to include the reason the resident will no longer receive Medicare coverage in the letters.	F 156			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to perform maintenance services necessary to maintain in good repair the tiled flooring in the main dining room and the baseboard in Resident #5's room. This had the potential to decrease the quality of	F 253	<u>F 253</u> Corrective action for residents found to have been affected by this deficiency: Resident 5's wall inspected and repaired by maintenance team, and base board replaced on 3/12/15 and 3/13/15. Main dining room floor to be replaced with new flooring. CNA interviewed was inserviced regarding proper maintenance reporting procedures when issued are noted. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns because all have base boards in their rooms and all residents have the choice to eat in the main dining room.		

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F 253	Continued From page 4 life for any residents using the dining room and for Resident #5. Findings included: During the environmental tour on 3/12/15 at 10:00 a.m., the tile floor in the main dining room was noticed to have two cracks. One of the areas was at the back of the dining room from the wall to the windows and the other was at the front of the dining room from wall to wall. The Maintenance Manager was present and stated a flooring company was contacted and on 3/16/15 would provide an estimate to repair the tile. During the initial tour on 3/9/15 at 12:45 p.m., Resident #5's room was observed to have what appeared to be water damage along the base of approximately 8 feet of wall. The baseboard was missing on the wall where the water damage was observed. On 3/10/15 at 10:20 a.m., CNA #1 stated the shower next door had been leaking water and caused the damage. The CNA stated the damage to the wall had occurred less than "6 months ago." During the environment tour on 3/12/15, the Maintenance Manager stated he was unsure how long the baseboard had been missing but a work order had been placed to repair the wall. On 3/12/15 at 3:45 p.m. the Administrator and the DON were informed of the above concerns. The facility provided no further information.	F 253	All rooms to be inspected by maintenance team for any missing base boards and any problems observed will be immediately fixed. Small dining room floor to be inspected by administrator for any cracks or similar issues as the main dining room. Root cause and measures that will be put into place to ensure that this deficiency does not recur: Root cause of the cracked dining room floor is it's been worn from years of use and missing base board was caused by shower room leak next door. Dining room floor to be replaced with a thicker, more durable material. Shower leaked was fixed prior to survey but the affected floor board was not replaced. All rooms to be inspected by maintenance team for any problems with base boards and any noted problems will be fixed by 4/17/15. Inservice provided to staff prior to 4/17/15 by facility safety officer on procedures to report maintenance problems. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Administrator or designee will audit the base boards in 5 rooms weekly for a period of at least 12 weeks beginning the week of 4/12/15 with any noted issues being fixed immediately. The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.	
F 280 SS=E	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	F 280		4/17/15

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F 280	<p>Continued From page 5 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: Based on observation, staff interview and record review, it was determined the facility failed to ensure resident care plans were updated to reflect current care residents were receiving. This was true for 4 of 9 (#s 1, 2, 3 & 7) sampled residents and one (#11) random resident and created the potential for harm should residents receive incorrect care or not receive care and services necessary to improve or maintain their highest practicable level of well being. Findings include:</p> <p>1. Resident #1 was admitted to the facility 11/19/14 with diagnoses of senile dementia, depressive disorder, and fracture tibia and fibia.</p> <p>The resident's comprehensive care plan, dated 1/20/15, for CHF (Congestive Heart Failure)</p>	F 280	<p><u>F280</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident 1,2,3,7 were affected by this deficit practice.</p> <p>-Resident # 1 care plan was updated to reflect the dc of the oxygen, the use of bilateral half side rail to aide with bed mobility/ positioning and access to bed adjustment control per Physician order</p> <p>-Resident #2 discharged from the facility on 3/16/15</p> <p>-Resident # 3 diabetes care plan was updated to reflect physicians orders i.e. call MD if blood sugar is less than or equal to 70 mg/dl.</p> <p>-Resident # 11 care plan was updated on 3/12/15 at 0900 to reflect the hypoglycemia physician orders i.e. Hypoglycemia :If BG < or equal to 70 mg/dl</p> <p>-Resident # 7 physician order on where to take to blood pressure was clarified with MD to state as follows: Obtain blood pressure to non-dialysis access site area i.e. Right arm and care plan was updated to reflect change.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>- Residents with oxygen use, side rail / assistive device use, diet orders and residents on short acting insulin have the potential to be affected by the deficient practice.</p>		

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F 280	<p>Continued From page 6</p> <p>documented, "I need you to make sure I have my oxygen on at 2/L (liters) by nasal canula [sic] to keep my sats [blood oxygen saturation levels] greater than 90%." Start date: 2/8/15. Based on observations on 3/10/15 through 3/11/15, the resident was no longer using oxygen.</p> <p>The resident's comprehensive care plan, dated 1/20/15, for ADL functional / Rehabilitation Potential, documented, "I have a [one] half rail to my left side for bed control use. Assist me with repositioning while I am in bed." The physician on 3/4/15 ordered the resident to have "half side rails [bilateral] to aide with bed mobility, positioning and access to bed adjustment control." The resident was observed to have both side rails up during the survey.</p> <p>2. Resident #2 was admitted to the facility on 1/17/15 with diagnoses of anxiety, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>The resident's comprehensive care plan, dated 1/29/15, for Nutritional Status documented, "I need therapeutic Gluten Free, cardiac diet, diced meats...and thin liquids."</p> <p>The Care Plan's Problem of Skin Alteration section documented, "My diet: Cardiac, gluten free diet, pureed meats." A second care plan for the same Problem documented the same Intervention. The resident was observed to eat a diet with diced meats, not a pureed diet.</p> <p>3. Resident #3 was admitted to the facility 2/8/12 with diagnoses of rheumatic aortic disease, Diabetes Mellitus Type II, and depression.</p>	F 280	<p>-The IDT reviewed Physicians orders to ensure that it is reflected in their care plan. There will be no other residents who will be affected with the deficiency for resident #7 since the facility has only resident #7 on hemodialysis treatment and there are no other residents with functioning fistula sites.</p> <p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>- The root cause of the deficiency are the following:</p> <p>1. There is the lack of auditing system in place to ensure that new physician orders are updated in the care plan. The IDT prior to the daily stand up meeting will review daily Physician order Monday to Friday and ensure that any changes necessary will be reflected in the care plan. The night nurse duties will be specifically updated to include auditing of charts of residents with new orders. The license nurses were also in serviced by Director of Nursing regarding the importance of care plans and issues that may incur when plan of care are not revised accordingly.</p> <p>2. There is redundancy in the Care plan intervention for dietary approach for residents with skin problems which will increase error rate when a diet order is revised. The care plan of residents with skin issues will be reviewed weekly by the IDT during the weekly skin committee meeting to ensure that diet orders will only be reflected under the Dietary section of the care plan. The skin nurse was educated by Director of Nursing to reflect this change.</p>	

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PRINTED: 03/25/2015
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 7</p> <p>The resident's comprehensive care plan, dated 11/27/14, for Diabetes Mellitus documented, "If blood glucose (BG) is less than or equal to 60 mg /dl, follow the hypoglycemic protocol." The physician's orders, dated 2/5/15, documented, "1. Call MD if BG is less than or equal to 70 [mg / dl]."</p> <p>4. Resident #11 was admitted to the facility 2/6/15 with diagnosis of Diabetes Mellitus Type II.</p> <p>The resident's comprehensive care plan, dated 2/23/15, for Diabetes Mellitus documented, "Monitor for signs of hypoglycemia (blood glucose <60 mg/dl...)" The facility's "Diabetes Management Protocol," signed by the physician on 2/5/15, documented, "Hypoglycemia: If BG < or equal to 70 mg/dl...."</p> <p>On 3/12/15 at 8:50 a.m. the DON was interviewed about the care plan issues found. The discrepancies were corrected after the interview. No further information was provided.</p> <p>5. Resident #7 was admitted to the facility on 4/17/14 with diagnoses which included end stage renal disease and hypertension.</p> <p>The resident's 2/1/15 - 2/28/15 Physician Order Report documented an order with a start date of 9/20/14: "FYI - do not take blood pressures on the arms. Use her legs only."</p> <p>The resident's 2/2/15 renal failure care plan included in the Approach section, "I need you to not take B/P (blood pressure), start IV or draw blood from shunt arm: left arm."</p>	F 280	<p>3. There is lack of auditing system for auditing Physician orders and care plan for newly admitted residents. The IDT will review charts of newly admitted residents the next day after admission Monday to Friday and 1 week after to ensure that the developed care plan is updated accordingly.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>-The DNS/Designee will conduct daily audits Monday to Friday for at least 12 weeks beginning the week of April 12. The audit results will be discussed during the QA committee meeting. Any concerns will be addressed immediately and discussed with the QA team as indicated. The team may adjust the frequency of monitoring as it deems appropriate.</p>	4/17/15

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F 280 F 281 SS=D	<p>Continued From page 8</p> <p>On 3/12/15 at 1:50 p.m. the DON was informed of the above concern. The facility provided no further information.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents received diabetic care and medications that met clinical standards of practice. This was true for 1 of 2 (#s 11) random residents. This created the potential for harm if diabetic care and medications were not provided on schedule in relation to meals. Findings include:</p> <p>The information at http://www.humalog.com, provided by the drug manufacturer Eli Lilly and company LLC, dated 2014, documented, "How should I use Humalog? Humalog is a rapid-acting insulin. Take Humalog within fifteen minutes before eating or right after eating a meal."</p> <p>Resident #11 was admitted to the facility 2/6/15 with diagnoses of Diabetes Mellitus Type II. During the medication pass on 3/10/15 at 11:31 a.m., the resident received Humalog insulin 27 units subcutaneously. The surveyor observed the resident, who did not receive his/her meal until 12:15 p.m., a 45 minute interval between receiving the Humalog insulin and eating.</p>	F 280 F 281	<p>F281</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident # 11 was affected by this deficient practice. -Resident #11 was discharged from the facility to home on 4/2/15.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>-Residents who are receiving short acting insulin have the potential to be affected by this deficiency. The IDT reviewed residents who are on short acting insulin and updated the time of administration to reflect the medication to be administered 15 minutes prior to or right after eating a meal per manufacturer recommendation.</p> <p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>-The root cause of the deficiency are as follows:</p> <ol style="list-style-type: none"> 1. The license nurse did not follow the recommended administration time. The nurse affected was educated by Director of Nursing. The license nurses will be in serviced on F-281 regarding the importance of following the recommendation for insulin administration by Director of Nursing. 2. Insulin administration time did not reflect resident preferences. The IDT will review all residents receiving insulin to reflect resident preference and update their diabetic plan of care accordingly. 3. The physician orders for short acting insulin does not include recommendation per drug company recommendation for administration. 	

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F 281	Continued From page 9 The Administrator and DON were interviewed on 3/11/15 about the insulin administration issue. The DON indicated the times were already being changed so residents get their meals right after administration of the medication.	F 281	The current residents with short acting insulin orders and MAR were updated to add to be administered 15 minutes before eating or right after eating a meal. The license nurses will be in-serviced by Director of Nursing to ensure better understanding and compliance.	
F 287 SS=B	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment.	F 287	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DNS or designee will audit licensed nurses during administration of insulin 3 times a week for at least 12 weeks beginning the week of April 12. Any concerns will be addressed immediately, fixed, and discussed with the QA team as indicated. The team may adjust the frequency of monitoring as it deems appropriate.	4/17/15

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F 287	<p>Continued From page 10</p> <p>(iv) Significant correction of prior full assessment.</p> <p>(v) Significant correction of prior quarterly assessment.</p> <p>(vi) Quarterly review.</p> <p>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.</p> <p>(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.</p> <p>(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by: Based on MDS database review and staff interview, it was determined the facility failed to encode and transmit resident discharges within seven days after residents were discharged. This was true for 16 or 16 (#s 14 - 29) discharged residents reviewed. Findings include:</p> <p>The following residents were identified as discharged from the facility. The MDS database revealed that each resident did not have a submitted discharge tracking form. The database revealed the facility admitted the residents, and the residents were still in the facility at the time of the survey. The residents were:</p> <p>Resident #14 - Discharged 9/26/14, Resident #15 - Discharged 9/7/14, Resident #16 - Discharged 9/30/14 Resident #17 - Expired 8/10/14, Resident #18 - Discharged 8/8/14,</p>	F 287	<p><u>F287</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Residents 14-29 were affected by this deficient practice.</p> <p>Discharge tracking form re-transmitted for affected residents.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by this deficiency since at some point everyone will discharge from the facility.</p> <p>Full audit completed by MDS nurse of discharged residents from 6/1/14 through present to ensure discharge tracking forms were transmitted to CMS.</p> <p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Root cause for this issue is that no tracking system was in place to ensure discharge forms were transmitted to CMS.</p> <p>Inservice provided to MDS nurses by Director of Nursing regarding F-287 specific to discharge tracking form submissions.</p> <p>MDS tracking form created for each patient to be reviewed weekly in PPS meeting to ensure transmission of discharge forms is done for discharge residents.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p>	

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F 287	Continued From page 11 Resident #19 - Discharged 10/29/14, Resident #20 - Discharged 1/9/15, Resident #21 - Discharged 7/19/14, Resident #22 - Discharged 6/2/14, Resident #23 - Discharged 10/31/14, Resident #24 - Discharged 12/29/14, Resident #25 - Discharged 9/10/14, Resident #26 - Discharged 10/1/14, Resident #27 - Discharged 8/8/14, Resident #28 - Discharged 9/8/14, and Resident #29 - Discharged 8/19/14. The MDS Coordinator was interviewed 3/10/15 at 11:00 a.m. and indicated she was new to the position and was not sure what happened prior to her hire. The Administrator was informed on 3/12/15 at 3:45 p.m. No further information was provided.	F 287	Administrator or designee will audit all discharged residents weekly for a period of at least 12 weeks starting the week of 4/12/15 to ensure discharge tracking forms were completed and transmitted, and that new MDS patient tracking forms are being reviewed with any issues noted being immediately corrected. The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.	4/17/15
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	F 314	F314 Corrective action for residents found to have been affected by this deficiency: Resident # 5 was affected by this deficient practice. -IDT reviewed and revised Resident # 5 skin care plan to reflect appropriate and accurate approaches that are currently being applied to the resident. Corrective action for residents that may be affected by this deficiency: -Every resident that score 18 or below on BRADEN assessment has the potential to be affected by the deficient practice.	

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F 314	<p>Continued From page 12</p> <p>to prevent the development of a pressure ulcer. This was true for 1 of 3 (#5) sampled residents. This deficient practice created the potential for more than minimal harm when the facility failed to implement preventative measures and a resident developed a Stage II pressure ulcer. Findings included:</p> <p>Resident #5 was admitted to the facility on 2/10/14 with multiple diagnoses which included chronic airway obstruction, urine retention, and diabetes mellitus.</p> <p>The resident's Incident/Accident Reporting Form, dated 2/5/15, had an "x" in the area to document; "Skin (bruise, skin tear, pressure sore..." The Brief Description of Incident section documented, "...wound on right heel approx (approximately) 1.8 cm x 2.1 cm (centimeters). Skin is intact with dark red non-blanching wound."</p> <p>Poor circulation, history of diabetes, COPD (chronic obstructive pulmonary disease) and neuropathy was hand written in the Root Cause section of the incident report. The plan of care initiated post discovery documented barrier cream and a dressing. The I&A documented the resident's heels were "already floated prior to incident."</p> <p>The resident's Wound Evaluation Flow Sheet (WS) documented the start date of the pressure ulcer on 2/5/15. On 2/9/15, the wound was documented as 1.3 cm in length, 1.3 cm in width and the depth was unknown. The stage was documented as a skin deep tissue injury. Weekly measurement from 2/16/15 through 3/9/15 documented the wound decreased in size to 0.5</p>	F 314	<p>The IDT will review the BRADEN score assessment for all the residents. Identified residents will have their Skin Care plan reviewed and revised as necessary to reflect appropriate and accurate interventions are in place to prevent the development of pressure ulcers.</p> <p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>-The root cause of this deficiency is the lack of system in auditing skin care plan of residents with skin issues. The IDT will review skin care plans weekly during the skin committee meeting to ensure that accurate and appropriate interventions are in place for the affected residents.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>-The DNS/Designee will audit skin care plans q week x 12 weeks beginning the week of April 12. Any concerns will be addressed and fixed immediately and discussed during the QA meeting. The frequency of the audit will be adjusted as deemed necessary by the QA team.</p>	4/17/15
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F 314	<p>Continued From page 13</p> <p>cm in length, 0.5 cm in depth and 0.1 cm depth and was a Stage II ulcer.</p> <p>The surveyor observed the wound on 3/12/15 at 9:00 a.m.. The area, on the right heel, presented with a red area of 0.5 cm diameter with no depth and no open area.</p> <p>The resident's 3/17/14 Skin Integrity Care Plan, in place on 2/5/15, included an intervention for weekly skin assessments, low air loss bed, podiatry consult, reposition as needed and floating the heels as needed.</p> <p>On 3/12/15 at 11:10 a.m. the DON stated the Skin Integrity Care Plan intervention to float the resident's heels should have been at all times rather than just as needed. The DON stated the Care Guide the CNA's referred to for resident care included in the Skin Care section direction to float the resident's heels when in bed. The DON stated she would look for documentation that the resident's heels had been floated prior to 2/5/15</p> <p>Note: The Skin Care section on the Care Guide included direction to float the resident's heels in bed, however that intervention was dated 10/15/15 and 12/10/15. Lines were drawn through the dates, indicating they were discontinued. Additionally, it was unclear how the intervention had been initiated on dates that had not occurred yet. The DON provided Nurses Progress Notes, dated 9/20/14, that documented, "Floating heels, freq. repositioning, weekly skin checks," however no other documentation was provided that the heels were floated.</p> <p>The Wound Nurse (WN) stated the pressure ulcer was "unavoidable" due to the co-morbidities</p>	F 314			

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F 314	Continued From page 14 of COPD, renal insufficiency, cardiac issues, neuropathy, diabetes, edema and limited mobility. The WN also stated the resident was non-compliant with his diabetes diet, which would have caused circulatory impairment that would have then caused the pressure ulcer. The Administrator and the DON were informed of the above concern on 3/12/15 at 3:45 p.m. The facility provided no further information to resolve the issue.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to offer residents the opportunity to use the toilet. This was true for 1 of 6 residents (#6) sampled for toileting assistance. The deficient practice had the potential to cause complications, such as skin breakdown or infections, from becoming incontinent of urine. Findings include: Resident #6 was admitted to the facility on	F 315	<p><u>F315</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #6 was affected by this deficient practice. -The IDT reviewed the bowel and bladder status of the resident and updated his toileting care plan accordingly to reflect his current status. The CNA and License Nurse involved were educated regarding the importance of following the toileting care plan of resident #6</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>-All incontinent residents have the potential to be affected by this deficient practice.</p> <p>The IDT reviewed all residents who were incontinent of their bowel and bladder via record review and resident / staff interview. This measure is to ensure that affected residents have current bowel and bladder assessments that reflect their current status accurately and their toileting care plan is updated accordingly.</p>	

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F 315	<p>Continued From page 15</p> <p>10/9/13 with diagnoses which included dementia with depression, insomnia and pain.</p> <p>The resident's 10/10/14 annual MDS assessment documented he required extensive assistance of 1 for toileting, was always incontinent, and was on a toileting program.</p> <p>The resident's 1/10/15 toileting Care Plan (CP) documented in the Approach section to have a staff assist the resident to toilet before and after meals and as needed.</p> <p>The resident's 1/10/15 Bowel Incontinence CP included an approach to assist the resident to toilet before and after meals, at bedtime and as needed.</p> <p>The resident's 1/26/15 Urinary Continence Evaluation documented in the "Specify plan below" section the resident was to be toileted before and after meals</p> <p>On 3/10/15 from 12:00 - 1:20 p.m. Resident #6 was observed in the dining room being assisted to eat his lunch. At 1:20 p.m. LN #3 was observed to push the resident in his wheelchair to watch television in the common area. LN#3 requested CNA #2 to transfer the resident from his wheelchair to the recliner. The CNA transferred the resident to the recliner and left the area. The resident was observed to remain in the recliner until 2:25 p.m.</p> <p>On 3/12/15 at 1:50 p.m. the DON was informed of the above concern. No further information was provided.</p>	F 315	<p>Root cause and measures that will be put into place to ensure that this deficiency does not recur:</p> <p>-The root cause of this deficiency is the staff not following the toileting care plan for the resident. The nursing staff will be in serviced in F-315 regarding Bowel and Bladder Assessment /Toileting Care plan development and the importance and consequences if care plan is not followed by Director of Nursing.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>-The DNS/Designee will audit 2 staff members daily regarding following toileting care plans for at least 12 weeks beginning the week of April 12. Any concerns will be addressed immediately and discussed during the QA meeting. The frequency of the audit will be adjusted as deemed necessary by the team.</p>	4/17/15
F 329	483.25(I) DRUG REGIMEN IS FREE FROM	F 329		

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PRINTED: 03/25/2015
FORM APPROVED
OMB NO. 0938-0391

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F 329 SS=E	<p>Continued From page 16 UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications for medication use. This was true for 4 of 9 (#s 5-8) residents sampled for psychoactive medications. This failed practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p>	F 329	<p><u>F329</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident 6- sleep hours will be tracked and documented during both day and night shifts on behavior monitoring sheets. Trazadone dosage will be decreased as a trial reduction.</p> <p>Resident 8- sleep hours will be tracked and documented during both day and night shifts on behavior monitoring sheets. Resident will be evaluated by physician to determine stated ineffectiveness of sleep medication and intervene as deemed necessary.</p> <p>Resident 5- behavior care plan reviewed and updated by IDT for specific depression indicators to be monitored on behavior monitoring sheets each shift. Resident's trigger for behaviors and refusal of care approaches will be added in the care plan. Lexapro dosage will be decreased as a trial reduction.</p> <p>Resident 7- behavior care plan reviewed and updated and specific behaviors related to her mental health diagnosis to be tracked on behavior monitoring sheets each shift. Seroquel dosage will be decreased as a trial reduction.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents with psychotropic medications and behavior monitoring forms have the potential to be affected by these identified concerns.</p>		

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F 329	Continued From page 17 1. Resident #6 was admitted to the facility on 10/9/13 with diagnoses which included dementia with depression, insomnia and pain. The resident's 10/10/14 annual MDS assessment documented the resident did not have trouble falling asleep or sleeping too much. The resident's 2/1/15-2/28/15 recapitulation Physician Order Report included an an order for Trazodone (antidepressant) 50 mg at bedtime for insomnia with a start date of 1/1/14. The resident's 1/10/15 Mood State Care Plan (CP) documented the resident displayed mood distress as evidenced by insomnia/change in usual sleep pattern. The approach section included to encourage the resident to "be up and active during the day so I will sleep better at night." During observations the following was documented: 3/10/15 10:00 - 11:00 a.m. asleep in bed 3/10/15 - 3:30 - 4:30 p.m. asleep in bed, at 4:30 p.m. the resident informed the surveyor he was going to go "back" to sleep. 3/11/15 - 8:50 - 11:45 a.m. - asleep in bed The Behavior/Intervention Monthly Flow Records (BIM) for 2/15 and 3/1-3/9/15 had the area to document hours of sleep on the day shift and evening shift marked off. The hours of sleep for the night shift documented the resident would sleep 7-8 hours each night.	F 329	IDT to review all behavior tracking forms for patients on psychotropic medications to ensure appropriate specificity of the behaviors being tracked and that they are all being completed on both shifts. Residents on sleep aide medication will have their sleep hours tracked on both day and night shifts. Root cause and measures that will be put into place to ensure that this deficiency does not recur: Root cause for this deficiency is the lack of tracking procedure for residents on sleep aide medications and the specifics of behaviors for residents on psychoactive medications. In-service given to nursing staff and social services by Director of Nursing on F-329 related to new procedure to track patients sleep who are sleep aid meds throughout the entire day and need for/reasoning behind tracking behaviors specific to related diagnoses. IDT will review all behavior monitoring sheets daily Monday-Friday to ensure appropriate and complete tracking is being done. Psychotropic committee will ensure dose reductions are attempted for patients on psychotropic medications unless documentation exists from their physician why a dose reduction would be clinically contraindicated. Each resident on psychotropic medications will be reviewed at least every quarter by the psychotropic committee consisting of mental health services nurse practitioner, pharmacist, DNS, social services, MDS, and administrator.	

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F 329	<p>Continued From page 18</p> <p>2. Resident #8 was admitted to the facility on 5/20/14 with diagnoses which included depressive disorder, anxiety state, bipolar and insomnia.</p> <p>The resident's 2/28/15 quarterly MDS assessment documented the resident was cognitively intact and did not have trouble falling asleep or getting too much sleep.</p> <p>The resident's 2/1/15 recapitulation Physician Order Report (POR) included an order for Trazodone (antidepressant) 100 mg for organic insomnia at bedtime with a start date of 5/20/14.</p> <p>The resident's 11/28/14 Care Plan (CP) for mood state identified the resident was unable to sleep well at night. The Approach section included "I sleep late at night and have a hard time getting my rest at night..."</p> <p>On 3/11/15 from 9:00 a.m. until 11:45 a.m. the resident was observed to be asleep in bed. When the resident was observed at 11:45 a.m. on 3/11/15 he was in bed but stated he would be going to the mid-day meal.</p> <p>On 3/12/15 at 8:20 a.m. the resident stated he did not think the Trazodone helped him sleep.</p> <p>Note: Resident Progress Notes documented on 2/3/15 the Trazodone was ineffective for sleep and on 2/2/15 the resident "denies effectiveness of Trazodone."</p> <p>The BIM for 2/15 and 3/1-3/9/15 had the area to document hours of sleep on the day shift and evening shift marked off. The hours of sleep for the night shift documented the resident slept an</p>	F 329	<p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Administrator or Director of Nursing will audit 3 residents (with at least 1 being on a sleep aid medication) on psychotropic medications daily Monday to Friday for a period of at least 12 weeks starting the week of April 12, 2015 to ensure sleep is being tracked both shifts (if applicable), specific behaviors related to diagnoses are being tracked, and that psychotropic committee has reviewed patient at least in the last quarter. Any issues noted will be immediately addressed.</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p>	4/17/15

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F 329	<p>Continued From page 19</p> <p>average of 5.1 hours at night the month of February. The 3/1/15- 3/10/15 form documented the resident slept 5-6 hours each night.</p> <p>On 3/12/15 at 1:50 p.m. the DON stated the hours of sleep for Resident #8 were not monitored as he had a history of sleeping in the day time. The DON stated the medication was not used for staff convenience at night but to help the resident sleep at night. When asked how it was determined the sleep on day shift and evening shift did not effect Residents #s 6 & 8's ability to sleep at night, the DON stated Resident #8 had always slept during the day. The DON stated for both residents the facility did not monitor hours of sleep except at night. The DON stated Resident #8 had not told her the sleep medication was not effective.</p> <p>3. Resident #5 was admitted to the facility on 2/10/14 with multiple diagnoses which included chronic airway obstruction, and diabetes mellitus.</p> <p>The resident's 2/1/15 recapitulation Physician Order Report included an order for Lexapro (antidepressant) 20 mg every day for depression with a start date of 10/31/14.</p> <p>The resident's 12/25/14 cognitive loss/dementia care plan approach section included to help the resident remain calm when he was frustrated or anxious. The CP did not include any information regarding how the behaviors were exhibited or to monitor the behaviors.</p> <p>The resident's 12/25/14 CP for mood stated the the resident expressed a sad mood, refused cares and had visual and auditory hallucinations of ghosts in his room.</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>The BIMs for 2/15 and 3/1/15 - 3/10/15 had areas to document sad/depressed mood, visual/auditory hallucinations and refusal of care. The BIMS documented no behaviors in the identified areas for 2/15 and 3/15.</p> <p>On 3/12/15 at 1:50 p.m. the Social Worker (SW) stated a trigger for the depression was when the resident started to talk about ghosts, however it was not identified as a trigger in the CP. The SW stated the hallucinations could occur as a symptom of a urinary tract infection (UTI) but the CP did not identify the UTI as a trigger. The SW stated the resident's depression was exhibited by the resident not attending favorite activities and requesting to go to bed. The SW was informed there was no documentation that either of those indicators were monitored. The SW stated she would expect staff to approach the resident more than 1 time before documenting a refusal, however the CP did not include how many times to approach the resident prior to documenting the refusal. Additionally the SW stated the criteria for the length of time to wait between refusals needed to be included in the CP.</p> <p>4. Resident #7 was admitted to the facility on 4/17/14 with diagnoses which included anxiety disorder, manic disorder, dementia and hypertension.</p> <p>The resident's 2/1/15 - 2/28/15 recapitulation POR included an order for Seroquel (antipsychotic) 25 mg 1/2 tablet twice a day for manic disorder.</p> <p>The resident's 2/2/15 psychotropic CP documented, agitation, behaviors of refusing</p>	F 329		
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F 329	<p>Continued From page 21</p> <p>cares (showering, dialysis) and packing her things and calling her family to leave the facility.</p> <p>The Approach section documented to:</p> <p>Attempt a dose reduction Assess if behaviors were a danger to the resident or others Assess effectiveness of medication Monitor behaviors</p> <p>The 2/15 and 3/1/15 - 3/10/15 BIM had an area to document refuses cares (showering and dialysis) packing/calling family to leave and agitation. The BIMs documented no behaviors.</p> <p>Note: The CP did not document how behaviors which were dangerous were exhibited. The BIM did not include how the behaviors were exhibited or an area to document the behaviors.</p> <p>On 3/12/15 at 1:50 p.m. the Social Worker (SW) was informed that refusal of cares did not justify the use of an antipsychotic medication. Additionally the data for refusals did not clarify if the behavior exhibited was refusing showers or dialysis. When asked how agitation was exhibited the SW stated the resident would pack her things and call her family. The BIMs were unclear if the agitation demonstrated was packing her things or other behaviors not identified in the CP. Without documentation of specific behaviors exhibited it would not be possible to document the effectiveness of the medication or interventions.</p> <p>The DON and the Administrator were informed of the above concerns on 3/13/15 at 8:15 a.m. The facility provided no additional information.</p>	F 329			

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F 514 F 514 SS=D	Continued From page 22 483.75(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 maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 1 of 6 (# 5) sampled residents whose recapitulation physician orders and treatment records were different then the resident's Physician Orders for Scope of Treatment (POST). This deficient practice increased the risk for medical decisions to be based on conflicting information. Findings included: Resident #5 was admitted to the facility on 2/10/14 with multiple diagnoses which included chronic airway obstruction, urine retention, and diabetes mellitus.	F 514 F 514	F 514 Corrective action for residents found to have been affected by this deficiency: Resident number 5 was affected by this deficiency. Resident 5's current recap and POST changed to match each other to be a DNR. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by this because everyone has a code status. Full audit completed by IDT to ensure code status matches up on POST form, MD orders, and monthly physician order recaps. Root cause and measures that will be put into place to ensure that this deficiency does not recur: Root cause of this issue is nurses completing monthly recaps not checking to see if a new POST was completed that month to ensure recap matches current POST. In-service provided by Director of Nursing to nurses on or before 4/17/15 on F-514 regarding proper procedures for monthly recaps.		

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F 514	<p>Continued From page 23</p> <p>The resident's 9/24/14 POST documented the resident did not want to be resuscitated and was no code.</p> <p>The resident's 2/1/15 recapitulation Physician Order Report (POR) included an order (start date 3/17/14 and end date 3/5/15) "code status: FULL CODE" with a line through it. The date it was discontinued was not documented. The 2/1/15 POR included another order which documented full code status with a start date 9/20/14 and "open ended".</p> <p>The resident's treatment administration form documented the 3/17/14 full code status as open ended and the 9/20/14 full code status as open ended.</p> <p>On 3/12/15 at 1:50 p.m. the DON stated the resident had changed from a full code status to a no code status.</p>	F 514	<p>An IDT member will review processed monthly recaps to ensure code status matches current POST and co-sign them before they are sent out to the physician for signature.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Administrator or Director of Nursing will audit the recaps and POSTs of 5 residents for at least 12 weeks beginning the week of April 12, 2015 to ensure code status matches MD orders matches and monthly recap. Any issues noted will be immediately addressed.</p> <p>The QA committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits.</p>	4/17/15	