



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 25, 2015

Trent B. Alder, Interim Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Alder:

On **March 13, 2015**, a Recertification and State Licensure survey was conducted at Franklin County Transitional Care by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 7, 2015**. Failure to submit an acceptable PoC by **April 7, 2015**, may result in the imposition of civil monetary penalties by **April 27, 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 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 7, 2015**. If your request for informal dispute resolution is received after **April 7, 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 that reads "Nina Sanderson (for David Scott)".

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

DS/dmj
Enclosures

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

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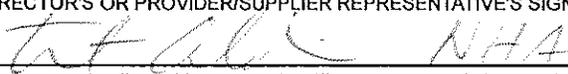
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263
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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	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification and State licensure survey of your facility. The survey team entered the facility March 9, 2015 and exited March 13, 2015. The survey team included Linda Kelly, RN, Team Coordinator, and Brad Perry, BSW, LSW. Survey 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	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		

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APR - 7 2015
DIV OF LIC & CERT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4/6/2015
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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>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;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>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 review of the facility's admission packet and staff interview, it was determined the facility failed to ensure 10 of 10 sample residents (#s 1-10) and all other residents in the facility were fully informed of their rights prior to or during the admission process. This created the potential for residents, or their representatives, not to have information about exercising their rights in the facility. Findings included:</p> <p>Review of the facility's admission packet on 3/12/15 revealed the information did not include the resident right to be fully informed of their health status in a language they could understand</p>	F 156			

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F 156	Continued From page 3 or their right to the deposit of funds. On 3/12/15 at 3:45 p.m., the Administrator was interviewed about the admission packet. When asked about residents' right to be fully informed of their health status in a language they could understand, the Administrator stated, "I couldn't see it." When asked about residents' right to the deposit of funds, the Administrator stated, "That one needs to be clarified. All I could see was about the valuables."	F 156			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The facility did not provide any other information about this issue. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164			

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F 164	<p>Continued From page 4</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain personal privacy for 1 of 9 sample residents (#5) and 1 random resident (#13). The failures created the potential for a negative effect on psychosocial well-being for Resident #5 whose torn care plan was thrown into an accessible trash can and for Resident #13 whose window blind was open during cares. Findings included:</p> <p>1. On 3/11/15 at 10:30 a.m., Resident #13's window blind was observed to be open when LN #1 administered a topical medication to the resident's labia. After that, the LN pulled up the resident's incontinence brief, assisted the resident to stand at the bedside, then assisted the resident to pull up her pants. A sidewalk and raised planter box were directly outside the resident's window.</p> <p>Immediately afterward, the LN was asked if she had noticed the window blind was open. The LN stated, "No, I didn't."</p> <p>2. On 3/10/15 at 3:19 PM, the MDS Coordinator was observed in the nurses station, which had two large open areas on either side of the desk that allowed staff and residents easy access to</p>	F 164		

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F 164	Continued From page 5 the area. She had a copy of Resident #5's care plan and had torn it up into four pieces and threw it into an open trash can. The resident's name and care plan interventions were visable when looked into the open trash can. On 3/10/15 at 3:25 PM, the MDS Coordinator was interviewed about the observation. When asked if she could see the care plan information by looking into the can, she stated, "Yes, you can." She acknowledged she should have used the covered shred bin which was located in an office nearby to discard the care plan.	F 164			
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and closed record review, it was determined the facility did not ensure a physician's discharge order was in place for 1 of 1 resident (#10) reviewed for discharge,	F 202			

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F 202	Continued From page 6 which created the potential for harm if the resident was discharged from the facility before he/she was ready for discharge. Findings included: Resident #10 was admitted to the facility on 12/8/14 with exacerbation of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The resident was discharged from the facility on 12/11/14. The resident's closed EMR (electronic medical record) contained Patient Progress Notes which documented: * 12/11/14 at 8:00 a.m. - "[Physician's name] into visit resident. Discharge orders pending." * 12/11/14 at 12:00 p.m. - "Preparing for discharge. 1600 [4:00 p.m.] dose of Rocephin [antibiotic] given...Heplock flushed...then DC'd [discontinued]...instructed...remove dressing and apply bandaid {supplied} in a couple of hours." The resident's closed paper clinical record also contained Discharge Instructions, dated 12/11/14. However, discharge orders, a note of the physician's 12/11/14 visit, and a Discharge Summary were not found in the paper- or EMR. On 3/12/15 at 2:20 p.m., the DON and the Administrator were asked to provide the discharge orders, the 12/11/14 physician visit note, and the Discharge Summary for Resident #10. The DON reviewed the resident's closed paper clinical record and EMR, conferred with the Administrator, made phone calls to EMR support staff, then said she could not find any of the requested documents.	F 202			
F 244	483.15(c)(6) LISTEN/ACT ON GROUP	F 244			

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F 244 SS=E	<p>Continued From page 7</p> <p>GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Resident Group interview, staff interview, and review of the Resident Council meeting minutes, it was determined the facility did not follow up on Resident Council concerns. This was true for 12 of 12 residents in the Resident Group interview and any other resident in the facility whose views and concerns were represented by the Resident Group. The deficient practice had the potential to cause psychosocial harm when residents felt they did not have a voice in the daily operation of the facility. Findings included:</p> <p>On 3/10/15, the Resident Council minutes from September 17, 2014 to March 2, 2015 were reviewed. Note: The facility's Resident Council met once every two months.</p> <p>The November 19, 2014 Resident Council minutes, documented a concern with CNA staffing: "Residents feel there needs to be no less [fewer] than four aides. Three is way too few...It just seems there aren't enough of them to go around."</p> <p>Resident Council minutes for January 12 and</p>	F 244			

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F 244	Continued From page 8 March 2, 2015 did not indicate the issue had been readdressed by the facility. On 3/10/15 at 3:30 PM, during the Resident Group Interview, the residents were asked about any staffing concerns. One resident stated the Resident Council had brought this issue up a few months prior, but the Council never received feedback from the facility on how the issue was resolved or if it had ever been reviewed by the facility. The rest of the group agreed the issue had not been addressed sufficiently by the facility. On 3/12/15 at 9:10 AM, the DON was interviewed regarding the group concerns and she said the facility had recently increased CNA staffing. She reviewed the January 2015 Resident Council minutes and stated she thought the issue had been resolved because the Council "... weren't talking about it anymore." When informed of the Resident Group concerns about the facility's lack of communication to the Council members, the DON asked the surveyor if there needed to be follow up by the facility regarding Resident Council concerns and the surveyor referred her to federal regulation F244.	F 244			
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 participate in planning care and treatment or changes in care and treatment.	F 280			

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F 280	Continued From page 9 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 resident and staff interview, it was determined the facility failed to revise care plans for 3 of 9 sampled residents (#s 1-3). The care plans: *failed to revise a urinary catheter size and frequency to change the catheter; *failed to document when a dietary intervention was implemented; *failed to document an intervention regarding the use of a timing device; and, This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in care plans. Findings included: 1. Resident #2 was readmitted to the facility on 2/14/15 with multiple diagnoses including peptic ulcer. The resident's Nutritional care plan, dated	F 280			

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F 280	<p>Continued From page 10</p> <p>2/14/15, documented a goal for weight gain; however, a handwritten intervention of, "Sandwich for her main entree lunch and dinner meal..." did not indicate a start date.</p> <p>The resident's meal tray card documented the main entree for lunch and dinner was a "sandwich only."</p> <p>On 3/10/15 at 5:20 PM, the resident was observed in her room eating her dinner meal, which included an egg salad sandwich. She stated she preferred sandwiches for lunch and dinner as her main entree.</p> <p>On 3/11/15 at 3:15 PM, the Registered Dietitian (RD) was interviewed regarding the care plan issue. She said she thought the intervention was implemented close to the resident's readmission date and acknowledged she failed to date the care plan intervention.</p> <p>2. Resident #3 was readmitted to the facility on 7/9/07 with multiple diagnoses including fracture of vertebral column.</p> <p>The resident's 1/2/15 quarterly MDS assessment documented the resident was continent of both bowel and bladder.</p> <p>The resident's electronic medical record under the section "Staff Communication," dated 2/18/15, documented, "Staff to set time for 30 min[utes] when re[ident] gets on BSC [bed side commode]; to return and offer to get her off..." The intervention was not found in the resident's care plan.</p> <p>On 3/10/15 at 9:10 AM, the resident was</p>	F 280			

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F 280	<p>Continued From page 11 interviewed regarding the use of the timer. She said she had been sitting on the commode too long and she wanted the timer as a reminder for her and staff to prevent skin breakdown.</p> <p>On 3/10/15 at 1:50 PM, the timer was observed to be turned on with 25 minutes left before it rang. The timer sat on a counter across the hall from the resident's room. The resident's door was opened with the privacy curtain pulled closed.</p> <p>On 3/11/15 at 1:40 PM, the MDS Coordinator was interviewed regarding the care plan. She said, "I didn't care plan it." When asked why the intervention had not been care planned, she said the timer was a trial to see if it was effective. When informed of the length the timer had been used, she acknowledged it and agreed it should have been care planned.</p> <p>3. Resident #1 was admitted to the facility in 2012 with multiple diagnoses including history of traumatic brain injury with subsequent diagnosis of cerebral palsy with spastic quadriplegia; other paralytic syndromes, paraplegia; and neurogenic bladder.</p> <p>The resident's clinical record contained documentation that the resident had a history of recurrent bladder infections until a suprapubic urinary catheter was implemented by a urologist in December 2013.</p> <p>The resident's care plan included the problems, "5/13/13 At risk for UTI [urinary tract infection] r/t [related to]: Indwelling catheter" and "12/03/13 16 Fr cath placed by [physician's name]." Interventions included, "...change</p>	F 280			

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F 280	Continued From page 12 catheter/catheter bag q [every] 3 weeks and prn [as needed]." A Report of Consultation by the urologist, dated 1/7/14, ordered, "Change S-P [suprapubic] q month 18 Fr[ench] foley [sic] cath[eter] [with] 8 cc [sterile water] in the balloon & [and] irrigate cath until clear [with] each change." And, the Nursing Orders, printed 3/10/15, included the same order. The clinical record contained documentation that the 18 Fr S-P was changed monthly. During observations of staff providing care on 3/10/15 at 11:25 a.m. and 3/12/15 at 9:30 a.m., the resident's S-P catheter was noted to be in place. On 3/11/15 at 10 a.m., the MDS Coordinator, who identified herself as the person responsible for care plans, was asked about the resident's care plan. The MDS Coordinator reviewed the catheter care plan and the resident's orders then acknowledged that the care plan needed to be revised. On 3/12/15 at 4:50 p.m., the Administrator and DON were informed of the care plan issues. The facility did not provide any other information regarding the issues.	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	F 281			

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F 281	<p>Continued From page 13</p> <p>by:</p> <p>Based on observation and staff interview it was determined the facility failed to ensure medication and oxygen (O2) were not administered by CNAs and residents rinsed their mouth and spit out the rinse water after inhaled corticosteroid medication. This was true for 3 of 9 sample residents (#s 1, 8, & 9) and it created the potential for Resident #1's antifungal spray powder and Resident #8's O2 to be administered incorrectly and for Resident #9 to experience mouth and throat discomfort. Findings included:</p> <p>1. On 3/10/15 at 11:25 a.m., CNAs #11 and #12 were observed as they provided pericare for Resident #1 after which CNA #11 sprayed Jock Itch, a medicated powder with 2% miconazole nitrate (antifungal medication), on a reddened area on the resident's right upper medial (inner) thigh.</p> <p>2. On 3/11/15 at 10:30 a.m., the Respiratory Therapist (RT) was observed as she administered Resident #9's corticosteroid medication, Flovent HFA (inhaler with the propellant hydrofluoroalkane). However, the RT did not encourage, offer, or instruct the resident to rinse her mouth before she left the resident's room.</p> <p>The Nursing 2015 Drug Handbook noted possible Adverse Reactions to Flovent as pharyngitis (sore throat), hoarseness, and laryngitis and Patient Teaching included, "Instruct patient to rinse his mouth and spit water out after inhalation."</p> <p>3. On 3/11/15 at 3:40 PM, Resident #8 was observed in her room sitting on her bed with her</p>	F 281			

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F 281	Continued From page 14 oxygen nasal cannula on and set at 3.5 Liters (L) per minute. The resident informed the surveyor the oxygen should be set at 4 L and asked the surveyor to turn it up. The surveyor explained he was not allowed and she said she would call for staff. The surveyor left the room and a minute later the resident's call light came on. A few minutes later the call light was turned off and CNA #5 was observed leaving the resident's room. On 3/11/15 at 3:50 PM, CNA #5 was asked what happened in Resident #8's room. CNA #5 said the resident's liter flow was at 3.5 L and was supposed to be set at 4 L. He stated, "She asked me to turn it up, so I did." On 3/12/15 at 9:27 AM, the DON was interviewed regarding the CNA administering oxygen. She said CNAs had been adjusting residents' oxygen without nurse oversight, because nursing staff had placed the resident's liter flow on a label on the oxygen wall unit for staff to see.	F 281			
F 314 SS=G	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	F 314			

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F 314	<p>Continued From page 15 prevent new sores from developing.</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 prevent avoidable pressure ulcers (PU) and that PUs were consistently and thoroughly assessed and monitored for 1 of 2 sample residents (#1) reviewed for PUs. Resident #1 was harmed when a previous Stage II PU at the left gluteal fold reoccurred as an SDTI (suspected deep tissue injury) then deteriorated to Stage IV with tunneling and osteomyelitis (infection of the bone); a right hip Stage II PU developed related to a catheter tubing; and, an SDTI developed to the right great toe from an unknown cause. Findings include:</p> <p>Resident #1 was admitted to the facility 4/11/12 with multiple diagnoses including history of traumatic brain injury with subsequent diagnosis of cerebral palsy with spastic quadriplegia; other paralytic syndromes, paraplegia; scoliosis with history of Harrington rod removal due to infection; artificial opening status, colostomy; muscle spasm; depression; and ulcerative lesions of the lower lumbar and sacral spine area.</p> <p>The resident's annual and three most recent quarterly MDS assessments, dated 6/26/14, 4/3/14, 9/25/14, and 12/18/14 respectively, all coded moderately impaired cognitive; short and long-term memory impairment; usually understood by others and able to understand others; extensive assistance for bed mobility, dressing, and personal hygiene; total assistance for transfers, eating, toileting, and bathing;</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>functional limitation in both upper and both lower extremities; colostomy and indwelling urinary catheter; and at risk for PUs.</p> <p>The 4/3/14 quarterly MDS also coded 1 unhealed Stage II PU and 1 unstageable PU due to SDTI, neither of which were present on admission or the previous MDS assessment. Skin/ulcer treatments included a pressure reducing device for the chair and bed, PU care, and application of ointments/medications other than to feet.</p> <p>The 6/26/14 annual MDS also coded 1 healed Stage II PU with skin/ulcer treatments of pressure reducing device for the chair/bed and application of ointments/medications other than to feet.</p> <p>The 9/25/14 quarterly MDS also coded 1 unstageable PU due to slough and/or eschar with skin/ulcer treatments of pressure reducing device for the chair/bed, PU care, and application of ointments/medications other than to feet.</p> <p>The 12/18/14 quarterly MDS also coded 1 Stage IV PU with the same skin/ulcer treatments as the 4/3/14 and 9/25/14 MDS assessments.</p> <p>The resident's 7/2/14 PU CAA documented the indicator was "existing" PUs and "...remains a high risk for developing pressure ulcers at this time..."</p> <p>The resident's care plan documentation included the following problems and their associated goals, approaches/interventions, and the date of change: * "5/01/12 Risk for Skin Breakdown Has history of pressure ulcers" - "Prevent pressure ulcer maintain/reduce RAPU [risk assessment for PUs]"</p>	F 314			

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F 314	Continued From page 17 score RAPU= 14 High risk" - "...Has air bed...10/16/12" "Use draw sheet...Reposition q [every] 2 hrs [hours] when in bed...6/15/12" "Uses air cushion in wheelchair; May be up for periods 2 hrs only...12/18/14" "...wears multi boots on both feet [undated]" "May go 4 hrs between positioning during the night to allow for deep sleep...8/21/12" "Catheter tubing positioned to maintain skin integrity q 2 hrs while awake and q 4 hours during the night...5/13/13." * "8/25/14 Impaired Skin Integrity...unstageable pressure sore...12/18/14 Now a stage IV" - "Ulcers will heal without complications" - "Wound care per policy/treatment sheet, Wound Specialist, physician [undated]" "Monitor, evaluate, readjust, and document interventions and outcomes [undated]" "Visits to wound clinic 2 x [times] month-follow Doctor's orders [undated]" * "12/18/14 Hx [history] of wound infection" - "...Most recent wound infection 11/26/14." * "4/14/12 Nutritional Status: Serious nutritional risk r/t complicated medical course...Hx pressure sore... - "Diet Order Regular with high protein supplements...6/15/12" - "8/25/14 Actual skin breakdown..." - "...wound will heal..." - "11/26/14 Infected wound-delayed healing" - "6 oz [ounce] high protein shake with each meal; 8 oz high protein shake between meals...8/25/14" "recommend zinc supplement...and iron supplement x 3 months until wound heals...8/25/14" "encourage fluids...8/25/14." - "2-8-15 Osteomyelitis..." - "wound & [and] bone infection will resolve..." - "Vancomycin [sic] IV [intravenous], Rocephin IV as ordered [undated]..." A 3/3/14 Incident Report (IR) for Resident #1 documented, "Found pressure sore stage II 3 x	F 314		

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F 314	<p>Continued From page 18</p> <p>[by] 2 x 0.1 [cm] in left gluteal fold...0.2 open area, serosanguinous drainage, small amt [amount]...Area cleansed and Mepilex border lite 4 x 4 placed...Recently it was decided that resident be allowed to make decision whether or not she should lay down after lunch... suggest...allow [resident's name] to feel like she has control by giving her a choice. For example: What movie would you like to watch while you are in bed?...[Resident's name]...mental age of a 4 or 5 yr [year] old. We are unable to educate her. She does not always comprehend consequences either...did lie down after lunch today...up for much longer periods of time the 2 days before." Equipment involved was a wheelchair. A 3/4/2014 Department Head Investigation documented, "...could be related to resident choice to sit up longer in chair. Will make return to former need to lay down after lunch...Skin nurse...to follow closely...approach above will be good for staff to adopt. Will discuss Staff Meeting 3/5/2014."</p> <p>The resident's Skin Assessment and Treatment records (SAT) and Skin Notes and Treatment Records (SN/TR) for March 2014 documented the left gluteal fold Stage II PU, labeled as "H1," on 3/3, 3/10, and 3/31. The SN/TR referred to photo mount sheets and on 3/31 noted the PU was, "Resolved..."</p> <p>The left gluteal fold Stage II PU photo mount sheet/assessment documentation included: * 3/3/14 - "Stage 2" PU, "Size (LxWxD [length by width by depth]) "3 x 2 x 0.01 cm [centimeters]," "Dressing/Comments: Wound cleansed...Mepilex...placed. Have repositioned resident off of area. Open area is 0.25 x 0.50 cm. Small areas superficial..." * 3/10/14 - "Stage II" PU, "Size...NA [not</p>	F 314			

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F 314	<p>Continued From page 19 applicable], "Dressing/Comments: Area cleansed [after] shower. Wound almost healed. Only pinpoint size area open...No measurements taken at this time." * 3/31/14 - "Dressing/Comments: Resolved skin intact and blanching..."</p> <p>There was no documented evidence the facility assessed/monitored the left gluteal fold Stage II PU for almost 3 weeks between 3/10-3/31/14 (20 days).</p> <p>The resident's S/A/T records and SN/TR for May and June 2014 documented a left "inner" thigh "abrasion," labeled as "A1." The SN/TR documented the abrasion on 5/19, referred to photo mount sheets, and on 6/17 documented "L inner thigh resolved." The facility provided only two photo mount sheet/assessments, 5/19/14 and 6/17/14.</p> <p>There was no documented evidence the facility reassessed/monitored the left inner thigh abrasion for 4 weeks between 5/19 and 6/17/14 (28 days). In addition, an IR regarding this abrasion was requested but was not provided by the facility.</p> <p>An 8/6/14 IR for Resident #1 documented, "...abrasion noted on left buttock area...where attends [sic] can slide across this spot." Contributing factors included, "Need to be careful when placing or taking attends off not to cause friction" and "Comments: Resident at high risk for skin concerns. This area of concern will be watched closely and care has been instructed to aides with placing and removing attends."</p> <p>The S/A/T records and SN/TR for August 2014</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>documented the left buttock abrasion noted on 8/6, was labeled "A1" until 8/27 when the label was changed to "L1" for unstageable.</p> <p>An 8/27/14 IR for Resident #1 documented, "...sore red area left inner thigh...abrasion like...dressing was removed...yellow slough in wound bed...This site was previously labeled A1- for abrasion when it was first noted on 08-25-2014, label changed to L1-unstageable on 8-27-2014. Photo placed in skin book..."</p> <p>Regarding contributing factors and witnesses, "NO ANSWER" was documented. And, comments by the DON on 10/14/14 (1 1/2 months later) documented, "Area noted by aide and then LPN got involved. Wound in different location. Resident has contractures of her legs. Left leg lays sideway when she is in bed. Area to be watched closely."</p> <p>Photo mount sheet/assessments regarding the "L1" SDTI/unstageable PU documented: * 8/27/14 - "(L) inner thigh" SDTI size 2 x 1.5, wound bed 80% yellow (slough), moderate amount serosanguineous drainage; Note: The next assessment was 10 days later. * 9/7/14 - "(L) inner thigh" "Pressure Ulcer...SDTI" size increased to 3 x 3.5, moderate amount serosanguineous drainage, wound bed yellow, and now foul odor and eschar present, "Offload-until consult [with] PT [physical therapy]; A 9/7/14 IR documented, "...found that wound advanced; pic taken." "Contributing factors: NO ANSWER." Comments, "Discussed with [LN's name]. This Unstageable is the same...left ischial tuberosity." * 9/11/14 - Location was changed to "(L) ischial tuberosity (IT)" size increased to 5.2 x 3, no odor, small amount serosanguineous drainage, wound</p>	F 314			

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F 314	Continued From page 21 bed 5% yellow & 80% eschar, "bone palpable...Off loading in bed. Roho placed in wheelchair yesterday." * 9/12/14 - (L) IT size 3.2 x 3, moderate odor, small amount serosanguineous drainage, 40 % yellow and 60% eschar after debridement by PT, "...Unable to determine depth D/T [due to] eschar present." * L1 was reassessed every 1 to 3 days between 9/17 & 9/26/14. * 9/26/14 - (L) IT size 3.4 x 3 x 2.6, wound bed 70% yellow, debrided by physician; * 9/29/14 - (L) IT size 3.6 x 3 x 2.8, wound bed 50% yellow & 50% red granulation, "Green drainage...foul odor...New wet to dry drsg [dressing]..." * 10/8/14 - (L) IT, "No eschar...depth... [increased]...Wet to dry drsg...Normal gel with Ag [silver]...in wound bed...Odor not as bad...started on Rocephin...10-7-14." * 10/24/14 - (L) IT size 8.4 x 4.4 x 3.8, large amount serosanguineous drainage, wound bed 30% yellow/70% red granulation, "...Wound vac placed with Santyl directly in wound bed..." * 10/27/14 - (L) IT size 2.5 x 1.6 x 3.5, "Drainage consistent with wound vac usage. Fowl [sic] odor...Resident showed signs of discomfort during wound cleansing." * 11/7/14 - (L) IT size 3 x 1.7 x 3, moderate amount green/yellow serous & sanguineous purulent drainage and foul odor, wound bed 70% "gray/brown," "...wound sides appear gray/brown...Yellow @ base appears thicker...on Wound vac..." * 11/12/14 - (L) IT, size 3 x 1.5 x 3.7, foul odor, wound bed 70% brown. * 11/14/14 - (L) IT size 2.6 x 1.6 x 4.4, large amount sanguineous drainage, foul odor. * 11/20/14 - (L) IT size 3 x 2.4 x 5, "Wound	F 314			

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F 314	<p>Continued From page 22</p> <p>debrided...at wound clinic on 11-19-14. Drsg [changed] this am per new order...</p> <p>* 11/24/14 to 3/9/15 - The PU size continued to vary. However, the depth of the PU increased and was noted as 7.8 on 12/29/14. On 1/9/15, 50% eschar in the wound bed was noted again. On 1/26/15, the PU was documented as a Stage IV and tunneling at the (L) and (R) side of the PU was noted for the first time. The (L) side tunneling was 9 cm (R) side was 6 cm. By 3/9/15, the PU size was 3.5 x 2 with 100% red granulation in the wound bed and (L) side tunneling was 8.5 while (R) side tunneling increased to 10.5.</p> <p>The resident's pelvis radiology report, dated 2/6/15, documented, "Osteomyelitis of the inferior left pubic ramus with destructive changes and abnormal periostitis and trabecular pattern."</p> <p>The resident's September 2014 SA/T also documented a new Stage II PU, labeled "H1," on 9/19 and documented as, "9/19...H1 - New - See photo mount sheet" in the September 2014 SN/TR. The "H1" PU was not mentioned again in either the September or October SA/T or SN/TR. However, the November 2014 SN/TR noted, "11/1...H1 (R) hip - blister - resolved - unknown when."</p> <p>The 9/19/14 (R) hip Stage II PU photo mount sheet/assessment documented, "Wound type blister-crater" size 3.7 x 0.5 cm" and "**Resolved. 11/1/14, see skin sheet."</p> <p>The IR and all documentation regarding the (R) hip Stage II PU was requested. On 3/13/15 at 3:00 p.m., the DON informed the surveyor that an IR was not found. However, the DON provided the resident's Patient Progress Notes (PNN) for</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>9/19 and 9/20/14. The PNN included a 9/19 entry which documented, "Skin...Open area, no weeping or bleeding, small sore on right back side hip. Looks like maybe from laying on cath hose."</p> <p>And lastly, a 3/25/14 IR for Resident #1 documented, "Lg [large] bruise or blood blister found to right great toe...had black boots on this shift. Found...when removing boots and getting her ready for bed...[no] s/s [signs/symptoms] of pain..." and "Suspect that toe was caught or smashed during a transfer more care should be taken when transferring resident." "Unknown" was documented regarding property or equipment involved. And, a 3/27/2014 Department Head Investigation documented, "...seen by DON. Not sure how this occurred as she has had boots on. Will be watched..."</p> <p>The SA/T records and SN/TR for March, April, and May 2014 documented the right great toe bruise/blister as an SDTI and the SN/TR referred to photo mount sheets.</p> <p>The right great toe PU photo mount sheet/assessments were dated 3/25/14, 4/7/14, 4/16/14, 4/24/14, 5/8/14, and 5/22/14.</p> <p>There was no documented evidence the facility assessed/monitored the right great toe SDTI between 3/25 & 4/7 (12 days), between 4/7 & 4/16 (8 days), between 4/24 & 5/8 (13 days), and between 5/8 & 5/22/14 (13 days).</p> <p>On 3/11/15 at 1:30 p.m., the DON was asked about the resident's 3/3/14 left gluteal fold PU, the 5/19/14 left inner thigh abrasion, the 8/6/14 (L) buttock abrasion that was changed to a (L) inner</p>	F 314		

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F 314	<p>Continued From page 24</p> <p>thigh SDTI on 8/27/14 and changed again to a left IT unstageable PU on 9/11/14, the 3/27/14 (R) great toe SDTI, and the 9/19/14 (R) hip Stage II PU. The DON asked LN #1 to join the interview. LN #1 compared the photo mount sheets for the aforementioned (L) gluteal fold/inner thigh PU/abrasions to the (L) IT PU photos then stated, "It's the same area. It depends on how she's laying. It's the same place." LN #1 said the "sideways" position of the resident's left leg and how the resident was positioned during assessments made it difficult to determine the anatomical location. The DON said she would review the resident's clinical record and meet again with the surveyor.</p> <p>On 3/12/15 at 9:30 a.m., Resident #1 was observed laying in bed while LN #6 and LN #7 prepared for the (L) IT Stage IV PU wound care/dressing change. The resident's hips were shifted to the right and her left leg was contracted laterally, or outward. The resident's toes were visible and all of them were intact without evidence of impairment. In addition, when the LNs repositioned the resident, the skin on her (R) hip was intact without evidence of impairment. LN #6 informed the surveyor that the old (L) IT dressing "fell off" during the resident's shower. LN #6 said she had already removed the packing and placed Vasche Wash soaked 4x4 gauze into the PU while the resident was in the shower room. LN #6 removed the soaked gauze, which she said had been in place for 10 minutes. The wound bed of the deep PU appeared to be 100% red granulation tissue, without drainage or odor, and the surrounding skin was pink and intact. LN #6 measured the PU tunnels, which were 9 cm on the (L) and 9.7 cm on the (R). The LN #6 then packed the PU, tunnels, and "the pocket where</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>the bone is in the center" with 2 inch wide Iodofoam, covered it with 2 small pieces of Mepilex, a 2x2 Mepilex, and a padded 4x4 border dressing which she secured at the inferior (bottom) aspect with Hypafix tape.</p> <p>On 3/12/15 at 11:00 a.m., the DON was again interviewed about the resident's PUs. The Registered Dietician (RD) was present. When asked when the Roho cushion was added to the resident's wheelchair (w/c), the DON said a w/c cushion was "always" in place since the resident was admitted and it was "upgraded" to the Roho. Regarding the 3/25/14 (R) great toe SDTI, the DON said the IR documented it could have happened during a transfer. The DON said she was sure she had talked to the staff involved but that she had not documented it. The RD said PU prevention interventions "haven't changed" since the resident was admitted to the facility. The RD provided information about osteomyelitis and said the resident's osteomyelitis could have been present "for years" before it "erupted." The RD added, "We don't know which came first, osteomyelitis then the wound or the wound then osteomyelitis." The DON called LN #6 and asked her to join the interview.</p> <p>On 3/12/15 at 11:45 a.m., LN #6 joined the interview with the DON and RD. When asked about the (R) great toe SDTI, the LN stated, "It happened during a transfer. It got bumped." When asked about the (L) IT PU, LN #6 stated, "In August I thought it was from her Attends [incontinence brief] so I had them [CNAs] take it off. Then I was off a couple of days and when I came back, the Attends was on again. The staff said it was a dignity issue. I had them take it off and leave off the Attends after that." LN #6 said</p>	F 314		

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F 314	Continued From page 26 the resident had another small area on the (R) inner thigh "that was caused by the Attends before the (L) side issue." The LN agreed to provide documentation about the (R) inner thigh issue, however, neither she, nor any other staff, provided any other information. On 3/12/15 at 2:30 p.m., the DON informed the surveyor the requested IRs were not found. Resident #1 was harmed when the facility failed to prevent new and recurrent PUs. The resident's (L) gluteal fold/inner thigh/IT PU reoccurred after incontinence briefs continued to be used, and it deteriorated to a Stage IV PU with 2 tunnels and bone infection; a catheter tubing caused pressure on the resident's hip; and, the cause of a (R) great toe SDTI was unknown. In addition, the facility did not consistently monitor and thoroughly assess the 3/3/14 Stage II (L) gluteal fold PU, the (R) great toe SDTI, or the (R) hip stage II PU. On 3/12/15 at 4:50 p.m., the Administrator was informed of concerns regarding PUs. The facility did not provide any other information which resolved the PU issues.	F 314		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

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F 328	<p>Continued From page 27</p> <p>Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who used oxygen: *had orders for oxygen; *received the liter flow as ordered by the physician; and, *had orders with liter flow parameters. This was true for 4 of 5 (#s 6-9) residents sampled for oxygen therapy. This failed practice created the potential for harm should residents receive oxygen therapy at different concentrations than ordered by the physician. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 12/8/14 with multiple diagnoses including congestive heart failure and hypertension.</p> <p>The resident's 12/8/14 Admission Orders, care plan, and March 2015 Physician's Nursing Orders Report did not document the resident received oxygen therapy.</p> <p>On 3/9/15 at 3:02 PM and on 3/10/15 at 9:05 AM, 11:25 AM, 1:52 PM, and 5:15 PM, the resident was observed in his room with oxygen on via nasal cannula (NC) set at 2 liters (L) per minute.</p> <p>On 3/11/15 at 4:15 PM, the MDS Coordinator was interviewed regarding the resident's oxygen. When asked if she could find oxygen on the care plan, she looked at the care plan and stated,</p>	F 328			

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F 328	<p>Continued From page 28</p> <p>"Nope." She also reviewed the current orders and admission orders and said she did not see orders for it, but knew the resident had been using it.</p> <p>2. Resident #8 was admitted to the facility on 1/3/09 with multiple diagnoses including congestive heart failure, interstitial lung disease and hypertension.</p> <p>The resident's Physician's Telephone Orders, dated 11/16/14, documented, "Do not titrate O2 [oxygen]. Leave on nasal cannula at 4 L/min[ute] forever more."</p> <p>The resident's ADL care plan, dated 1/20/09, documented the resident was to receive oxygen at 4 liters continuous.</p> <p>The resident's March 2015 Physician's Nursing Orders Report documented, "Maintain Sat[uration]s above 90%", but did not include the liter flow rate.</p> <p>On 3/11/15 at 3:40 PM, the resident was observed in her room sitting on her bed with her oxygen nasal cannula on and set at 3.5 liters per minute. The resident said the oxygen should be set at 4 liters, "Otherwise I get in real trouble." She said without the correct liter flow she would have breathing difficulties. Note: Refer to F281 regarding staff administration of oxygen.</p> <p>On 3/12/15 at 8:20 AM, the resident was observed in the dining room with an oxygen canister on her wheelchair with the liter flow set to 3 liters. The resident asked what the liter flow was set at and then said if it was not at 4 liters she would be really tired by that afternoon. She then</p>	F 328			

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F 328	<p>Continued From page 29</p> <p>asked for an LN to adjust her oxygen. At 8:21 AM, LN #9 was observed adjusting the resident's oxygen liter flow.</p> <p>On 3/12/15 at 8:25 AM, LN #9 was interviewed about the resident's liter flow and she stated, "It was on 3 liters and I changed it to 4 liters."</p> <p>On 3/12/15 at 9:27 AM, the DON was interviewed regarding the liter flow observations. She said the ordered liter flow should have been followed. She also said there was a lack of liter flow on the March Physician's Nursing Orders Report.</p> <p>3. Resident #9 was readmitted to the facility on 2/22/14 with multiple diagnoses including congestive heart failure and hypertension.</p> <p>The resident's ADL care plan, dated 3/11/13, documented the resident received oxygen at bedtime at 2 liters per minute.</p> <p>The resident's Physician Orders, dated 1/6/14, documented, "O2 via N/C [at] 2L/M[inute] to keep O2 saturation [at greater than] 90% PRN."</p> <p>The resident's March 2015 Physician's Nursing Orders Report did not document an order for oxygen.</p> <p>On 3/12/15 at 8:10 AM, the resident's room was observed. The oxygen wall unit contained a water humidifier, which indicated the oxygen had recently been used.</p> <p>On 3/12/15 at 9:20 AM, the DON was interviewed regarding the oxygen. She said the resident used oxygen when she slept. She was shown the current orders and was asked where it</p>	F 328		

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F 328	<p>Continued From page 30</p> <p>documented the resident received oxygen, when the resident was to wear it, and at what liter flow it should be set. She stated, "It's not on here."</p> <p>4. Resident #7 was admitted to the facility in 2012 with diagnoses which included congestive heart failure (CHF).</p> <p>The resident's Physician's Nursing Orders Report and Order Chronology report, both printed 3/11/15, and Physician's Orders for 8/1/14 to 9/30/14, all included the order, "O2 via N/C to keep O2 saturation > 90% [Oxygen via nasal cannula to keep oxygen saturation greater than 90 percent.]" The Order Chronology documented the O2 order was started 9/29/14, the Physician's Orders documented the order as 7/8/14, and the Physician's Nursing Orders Report did not include a date for the O2 order.</p> <p>The resident's care plan included the problem, "12/09/14 Continuous O2 @ 2 L [liters] per NC to keep O2 sats [saturation levels] above 90%."</p> <p>On 3/11/15 at 3:45 p.m. and 4:25 p.m., the resident was not in his room. However an O2 NC was observed on the resident's bed both times.</p> <p>On 3/12/15 at 9:10 a.m., the resident was observed in the dining room with a NC in place. The NC was connected to a portable O2 tank at the back of the resident's wheelchair. The O2 tank was set at 2 liters per minutes (LPM).</p> <p>On 3/12/15 at 11:00 a.m., the resident was observed with an O2 NC in place while asleep in the recliner in his room. The NC was connected to the O2 cylinder on the wall. The O2 wall</p>	F 328			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263		
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F 328	Continued From page 31 cylinder was set at 2 LPM. On 3/12/15 at 3:50 p.m., the DON was asked what O2 liter flow rate was ordered for Resident #7. The DON reviewed the O2 orders then acknowledged the liter flow rate was not in any of the orders.	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329			

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F 329	<p>Continued From page 32</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure 2 of 6 residents (#s 2 and 5) sampled for pain management were free from unnecessary medications when PRN (as needed) pain medications were not monitored for efficacy. The failure placed the residents at risk for overmedication and/or unrelieved pain. Findings included:</p> <p>1. Resident #2 was readmitted to the facility on 2/14/15 with multiple diagnoses including degenerative joint disease and chronic pain.</p> <p>The resident's March 2015 MAR included a 2/14/15 physician order for Oxycodone/APAP [Percocet] 10-325 MG as needed every six hours for pain. The MAR indicated the resident had received the medication 26 times from March 1 to March 10, 2015. There was no documentation indicating the medication was monitored for effectiveness.</p> <p>On 3/12/15 at 8:55 AM, the DON was interviewed regarding pain monitoring. She said the facility had recently converted orders into a new computer system and had not figured out how to document pain effectiveness for PRN pain medications.</p> <p>2. Resident #5 was admitted to the facility in 2013, and readmitted 1/17/14 and 6/1/14, with multiple diagnoses, which included generalized pain.</p> <p>The resident's March 2015 MAR included a 10/1/14 physician's order for hydrocodone/APAP 7.5/325 [brand name Norco] 1 or 2 tablets every</p>	F 329			

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F 329	Continued From page 33 four hours PRN (as needed) for pain. This MAR documented the resident received Norco 1 tablet 5 times between March 1 and March 9, 2015. However, there was no documented evidence in the resident's clinical records that the efficacy of the PRN medication was monitored. On 3/12/15 at 8:55 AM, the DON was asked where PRN pain medication effectiveness monitoring was documented. The DON said it was not documented because the facility had recently converted to a new computer system and had not determined how to document the effectiveness of PRN pain medications.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		

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F 356	<p>Continued From page 34</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to consistently post current nurse staffing information, which created the potential for minimal harm for 9 of 9 sample residents (#s 1-9), all other residents living in the facility, and visitors to the facility who may want to know the number of RNs, LPNs and CNAs on duty and the total hours for each of those disciplines for each shift. Findings included:</p> <p>On 3/10/15 at 5:30 p.m., the Daily Nurse Staffing information posted near the nurses' station was observed to be blank in the column for the 2 - 10 p.m. (evening) shift. The DON and LN #10, who were at the nurses' station, were asked about the missing information. The DON said, "I can fix that," and she filled in the information.</p> <p>On 3/11/15 at 5:00 p.m., the posted Daily Nurse Staffing information again did not included information for the evening shift. Immediately afterward, the Administrator and DON were informed of the issue.</p> <p>The facility did not provide any other information regarding the issue.</p>	F 356			

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F 368 F 368 SS=E	Continued From page 35 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on the Resident Group interview and staff interview, it was determined the facility did not offer a bedtime snack to all residents. This was true for 8 of 12 residents in the resident group, and had the potential to impact any resident in the facility who did not have a pre-arranged snack provided by the kitchen, or who were at risk for nutritional compromise. The deficient practice had the potential to cause harm if residents experienced hunger between dinner and breakfast, or did not receive adequate nutrition to support healing or prevent weight loss. Findings included: On 3/10/15 at 3:30 PM, during the Resident	F 368 F 368			

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F 368	Continued From page 36 Group interview, the residents were asked if snacks were offered at bedtime. The residents stated several residents had a pre-arranged snack provided by the kitchen, but 8 out of 12 residents said they were not offered snacks at night. On 3/10/15 at 5:10 PM, CNA #2 and CNA #3 were interviewed regarding bedtime snacks. CNA #2 was asked if snacks were offered to all residents and she stated, "Just certain residents." She said snacks were not offered to all the residents, but she would hand them out if residents asked. CNA #3 said snacks provided by the kitchen had labels with resident names printed on them for those who had special diets. She also said if residents were hungry, they would be offered snacks. On 3/12/15 at 9:10 AM, the DON was interviewed regarding bedtime snacks. She said the kitchen provided snacks to some of the residents. When asked about residents who did not have a pre-arranged snack through the kitchen, she said the surveyor would need to ask the evening aides. The surveyor informed her of the CNA interviews and she stated, "OK." On 3/12/15 at 4:50 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.	F 368			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431			

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F 431	<p>Continued From page 37</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a medication (med) pharmacy label included necessary information (concentration and expiration date) for 1 sample resident (#13); and, that expired meds and time sensitive meds without an open date were not available for</p>	F 431			

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F 431	<p>Continued From page 38</p> <p>resident use. These failures created the potential for more than minimal harm if Resident #13 received the wrong dosage of promethazine with Codeine and for any resident who may have received expired and/or opened and undated antianxiety or antidiarrheal medication, lidocaine for injection, and/or acetaminophen suspension. Findings included:</p> <p>1. On 3/11/15 at 11:35 a.m., during inspection of the B-Hall Med cart with LN #4 present, the following was found:</p> <ul style="list-style-type: none"> * The pharmacy label on promethazine/Codeine syrup for Resident #13 did not include the concentration for each medication or an expiration date; * A bottle of the antianxiety medication, hydroxyzine hydrochloride (HCL) syrup 10 milligrams/5 milliliters (mg/mL), expired August 2013; * An open 20 milliliter (mL) vial of "preservative free" 0.9% sodium chloride did not have an open date; * An open 50 mL bottle of 1% lidocaine HCL 10 mg/mL for injection did not have an open date; * 2 Loperamide HCL 2 mg tablets expired 12/2014; and, * A 100 mL bottle of acetaminophen oral suspension 160 mg/5 mL expired 12/2014. <p>LN #4 acknowledged the above findings and said the medication for Resident #13 was "not even from our pharmacy." The LN stated, "I'm gonna throw them all away."</p> <p>2. On 3/11/15 at 11:50 a.m., during inspection of the medication refrigerator at the nurses' station, with LN #1 present and LN #4 nearby, a 2.5 mL bottle of Travatan ophthalmic solution 0.004%</p>	F 431			

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F 431	Continued From page 39 which expired 1/2015 was found. LN #4 told LN #1 "Give it to me, I'll get rid of it."	F 431			
F 441 SS=D	On 3/12/15 at 4:50 p.m., the Administrator and DON were informed of the issues. The facility did not provide any other information about these issues. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441			

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F 441	<p>Continued From page 40 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff performed hand hygiene after glove removal following direct contact with urinary drainage bag emptying, peri care, and colostomy care for 1 of 3 sample residents (#1). Failure to adhere to standard infection control measures created the potential for infection related to cross contamination. Findings included:</p> <p>Resident #1 was admitted to the facility 4/11/12 with multiple diagnoses including history of traumatic brain injury with subsequent diagnosis of cerebral palsy with spastic quadriplegia; other paralytic syndromes, paraplegia; scoliosis with history of Harrington rod removal due to infection; artificial opening status, colostomy; and ulcerative lesions of the lower lumbar and sacral spine area.</p> <p>a) On 3/10/15 at 11:25 a.m., CNAs #11 and #12 were observed as they prepared to get Resident #1 up for lunch. CNA #11 emptied the resident's urinary bedside drainage bag then removed her gloves. The CNA did not perform any type of hand hygiene before she put on new gloves then provided pericare with CNA #12's assistance, sprayed Jock Itch medicated powder on the resident's right inner thigh (Refer to F 281,</p>	F 441			

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F 441	<p>Continued From page 41</p> <p>Professional Standards, for details regarding this deficient practice), removed the resident's colostomy bag, provided colostomy care, and applied a new colostomy bag then removed her gloves. CNA #11 did not perform any type of hand hygiene before she put on new gloves then assisted CNA #12 to put pants and a different top on the resident, transfer the resident from the bed to the wheelchair using a mechanical lift, and straightened the bed linens then removed her gloves. CNA #11 again did not perform any type of hand hygiene before she offered the resident a drink then held the Styrofoam cup barehanded with the straw between her bare fingers while the resident took sips. CNA #11 did not perform any type of hand hygiene before she put on new gloves, gathered up the trash, then left the room.</p> <p>On 3/10/15 at 11:50 a.m., CNA #11 was interviewed. When informed of the aforementioned observation and asked about infection control, the CNA acknowledged she had not performed any type of hand hygiene. She stated, "I was on the other side of the bed. You make me nervous."</p> <p>b) On 3/12/15 at 9:30 a.m., LN#7 was observed as she helped reposition Resident #1 before and after left ischial tuberosity wound care and dressing change by LN #6. During the process, the used laundry was placed on the sink. When the wound care/dressing change was completed, LN #7 walked to the sink and stated, "I'll wash my hands after I take the laundry." LN #7 then gathered the laundry in her gloved hands and left the room.</p> <p>On 3/12/15 at 4:50 p.m., the Administrator and DON were informed of the infection control issue.</p>	F 441			

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F 441	Continued From page 42 The facility did not provide any other information regarding the issue.	F 441			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 3 of 9 (#s 2, 8, & 9) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents not to have a handrail for stability when needed. Findings included: On 3/9/15 at 1:55 PM, approximately 4 feet on the right side and 5 feet on the left side of the Spa door in the A hallway were observed to be missing. On 3/12/15 at 10:00 AM, the Maintenance Supervisor was shown the missing handrails; he said the area had been remodeled and there had been three doors where there was now only one. He stated, "We have not put them up." On 3/12/15 at 4:50 PM, the Administrator and DON were informed of the issue. No further information was provided.	F 468			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514			

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F 514	<p>Continued From page 43</p> <p>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.</p> <p>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.</p> <p>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 2 of 9 (#s 8 & 9) sampled residents with incomplete documentation for oxygen orders and oxygen orders were not put into the facility's new computer system. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 1/3/09 with multiple diagnoses including congestive heart failure, interstitial lung disease and hypertension.</p> <p>The resident's Physician's Telephone Orders,</p>	F 514			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 44 dated 11/16/14, documented, "Do not titrate O2 [oxygen]. Leave on nasal cannula at 4 L/min[ute] forever more."</p> <p>The resident's ADL care plan dated 1/20/09, documented the resident was to receive oxygen at 4 liters continuous.</p> <p>The resident's March 2015 Physician's Nursing Orders Report documented, "Maintain Sat[uration]s above 90%", but did not include the liter flow rate.</p> <p>On 3/11/15 at 3:40 PM, the resident was observed in her room sitting on her bed with her oxygen nasal cannula on and set at 3.5 liters per minute.</p> <p>On 3/12/15 at 8:20 AM, the resident was observed in the dining room with an oxygen canister on her wheelchair with the liter flow set to 3 liters.</p> <p>2. Resident #9 was readmitted to the facility on 2/22/14 with multiple diagnoses including congestive heart failure and hypertension.</p> <p>The resident's ADL care plan, dated 3/11/13, documented the resident received oxygen at bedtime at 2 liters per minute.</p> <p>The resident's Physician Orders, dated 1/6/14, documented, "O2 via N/C [at] 2L/M[inute] to keep O2 saturation [at greater than] 90% PRN."</p> <p>The resident's March 2015 Physician's Nursing Orders Report did not document an order for oxygen.</p>	F 514			

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F 514	Continued From page 45 On 3/12/15 at 8:10 AM, the resident's room was observed. The oxygen wall unit contained a water humidifier, which indicated the oxygen had recently been used. On 3/12/15 at 1:15 PM, the DON was interviewed regarding the inaccurate and incomplete oxygen orders. She said in October 2014 the facility implemented a new computer system and had some difficulty correctly inputting the physician's nursing orders, including oxygen. On 3/12/15 at 4:50 PM, the Administrator and DON were informed of the order issues. No further information was provided by the facility.	F 514			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520			

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F 520	<p>Continued From page 46</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Quality Assurance Program (QAP) attendance records, it was determined the facility failed to ensure a designated physician attended the meetings. Without timely medical guidance and input into the QAP, the identification of problem areas and the development and implementation of appropriate plans of action to correct identified quality deficiencies may be inadequate and this had the potential to negatively affect 9 of 9 sample residents (# 1-9) and all other residents living in the facility. Findings included:</p> <p>On 3/11/15 at 4:10 p.m., the Quality Manager (QM) was interviewed about the facility QAP. When asked if a physician attended QAP meetings at least quarterly, the QM said "not usually." At that time, the QAP meeting attendance records since July 2014 were requested.</p> <p>On 3/12/15, the requested QAP attendance records were received. They were dated 9/30/14, 10/28/14, 11/25/14, 12/23/14, 1/27/15, and 2/24/15. Review of these records revealed that a physician had not attended any of the meetings.</p> <p>The facility failed to ensure the designated physician attended the QAC meetings as required.</p>	F 520			

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F 520	Continued From page 47 On 3/12/15 at 4:50 p.m., the Administrator and DON were informed of the issue. The facility did not provide any other information regarding the issue.	F 520			

PLAN OF CORRECTION FOR THE STATE OF IDAHO - FRANKLIN COUNTY MEDICAL CENTER - NURSING HOME

Date of Survey: 3-13-2015

Opportunity to Correct: April 17, 2015

POC deadline: April 7th 2015

Criteria: Include dates when corrective action will be completed.

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?
3. What measures will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur?
4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur?
5. Date corrective action will be completed

Signature of Administrator

[Handwritten Signature] N.H.A. 4/6/15

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
F156	C	#1-10		Resident Rights, Rules, Services
			1.	Admission packet will be modified to include "language that they can understand" and rights relating to interest bearing fund accounts will be signed by all residents/ resident representatives.
			2.	All residents are be affected by this
			3.	All new and current residents will be given a copy of the new corrected admission packet. Resident and/ or resident representatives will be mailed a copy of the new packet requesting a signature. 16 signed, 13 were mailed and 1 pending.
			4.	Each new admission for the next 3 months will be reviewed monthly by the unit secretary to ensure the new admission packet was used. This will be reported to the quality management officer monthly.
			5.	COMPLETION DATE = 4/7/15
F164	D	#5, #13		Personal Privacy/Confidentiality of Records – Pericare, blinds
			1.	On April 1, 2015 staff meeting, the licensed staff and CNA's were informed that personal privacy must be maintained by ensuring that the window blind is closed during personal cares and that papers with personal information on them cannot be thrown in the trash. Use of the shredder or proper disposal boxes must be used
			2.	All residents will be affected by this
			3.	See #1 above and a two new shredders were placed to be accessible to the staff. One in the copy room and one in the CNA office
			4.	a) Once a day for 5 days QM person will go through the trash at the end of the day to assure that there is not Personal protected information in the trash by the nurse's station. Then once a week for one week, then once a month for one month. b) Once a shift for days and evenings the LN will knock enter and observe that the window blind is closed during cares x 5 days, then twice a week x 3 week, then 5 x's random for days and afternoon shifts x one month.
			5.	COMPLETION DATE = 4/7/15
F202	D	#10		Documentation for Transfer/Discharge of Resident
			1.	No corrective action has been taken for resident #10 because this was a closed chart.
			2.	All residents who are discharged could be affected by this
			3.	A new policy was implemented and a checklist correlating with the policy will be followed and the LN

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TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
				will sign to show completion of all tasks. Nursing staff was educated to this process on 4/1/15.
			4.	The unit ward clerk will review the signed check list with the chart upon discharge to make sure of completeness and sign the form as well. We will monitor 100% of discharges for 3 months and the administrator will review the results. Results sent the QM committee monthly.
			5.	COMPLETION DATE =4/7/15
F244	E	12 of 12 Resident council		Listen /Act on Group Grievance/Recommendation
			1.	All resident council members were invited to an extra resident council meeting on 3/31/15. The council adopted an agenda and a new inquiry form to be used to address their concerns from the council. The new inquiry form will be sent to the appropriate department heads after the resident council meeting. The completed form will be given to the resident council president and an initialed copy given to the council secretary as a permanent record. It will be reviewed at the next meeting.
			2.	All residents could be affected by this.
			3.	See #1
			4.	Every resident council meeting for the next 6 times will be monitored via the form to be sure all concerns are addressed, and reported to Quality Management monthly by Activities and the administrator
			5.	COMPLETION DATE =4/7/15
F280	E	#1,2,3		Right to Participate Planning-Revise CP
			1.	Resident # 1 care plan was changed to the current orders; resident #2 a start date for sandwich was placed; resident #3 the timer was placed on the care plan
			2.	All residents could be affected
			3.	A white board(WB) had been installed in the CNA office for all Nursing Home staff to use anytime there is a problem that needs to be communicated to the rest of the staff they will use the WB. (a) Licensed staff will be trained to put received orders in the Medact and write on the WB. (b) The "Daily Standup meeting" will be held in the CNA office to review the WB, Monday through Friday. The charge nurse will ensure that the process is followed throughout the weekend using the WB process and add to the Care Plan(c) The MDS coordinator/ Licensed staff/ IDT staff will agree on problems/goals/interventions that should be added to the Care Plans at that time with start and stop dates by them . All staff will be responsible to read and be aware of the Care Plans and failure to do so will result in disciplinary action by the DON.
			4.	MDS coordinator makes sure all changes on the board or handwritten are put in the care plans daily M through F. She will print them weekly. 10% of care plans will be reviewed by the DON every week to ensure that the Med act and care plans are congruent. This will be reported to the QM monthly.
			5.	COMPLETION DATE =4/7/15
F281	D	#1,8,9		Services Provided Meet Professional standards- Medication powder, O2
			1.	On April 1, 2015 staff meeting, the licensed staff and CNA's were informed that only licensed staff can administer medications. That includes oxygen and medicated powder or medicated ointment. All personnel who offer inhalers with Corticosteroids will encourage, offer or instruct the resident to

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
				rinse their mouth and spit after inhalation. Resident # 8 and #9 were offered water and spit after use of inhalers since the visit from the state. RT will instruct all nurses on April 9 th on the proper administration of inhaled medications and the importance of encouraging, offering or instructing residents to rinse and spit out water after inhalation.
			2.	All residents who have oxygen, medicated powders or medicated ointment or inhalers can be affected
			3.	Respiratory Therapist will in-service nursing staff on April 9, 2015 about appropriate administration of corticosteroid inhalers/ propellant inhalers. Nurses and CNA's were together during the in-service regarding the responsibility of only nurses to observe O2 being turned on or adjusted. The nurse must observe medicated powders or ointments being administered to residents.
			4.	RT and Licensed staff will monitor one another when administering inhalers to ensure that residents are encouraged, offered or instructed to rinse their mouth and spit out water after inhalation. Monitoring of inhalation, initiating oxygen and administering powder/lotion will be done every day X7, then weekly x 2, monthly x 1 and reported to the QM monthly
			5.	COMPLETION DATE =4/7/15
F314	G	#1		Prevent/Heal Pressure Sores
			1.	On January 13, 2015 #1 resident's physician stated: "My feeling on the outcome of this wound, I do not think it is going to heal. We sent her to the wound center we have done antibiotics, we have done wet to dry, we have done wound VAC and it just seems not to be getting any better. We are having a very hard time healing this most likely due to the patient's poor protoplasm, her physical situation, and her poor blood flow." Never the less we continue to work with the wound care specialist in Logan; we are turning her q2h while in bed, repositioning q1h in chair, not allowing her to be up more than two hours in her wheelchair at a time as the resident allows. Her wheelchair has a Roho cushion, she has an air mattress on her bed which she has had since admission to our facility. We have removed all attends from her room and educated staff not to use any attends or stack chucks under resident. We have contacted the manufacturer of the air mattress to get their recommendation on what should be used on their air mattress surface.
			2.	Any resident who is admitted or who is currently resides here could be effected by this.
			3.	We are increasing the frequency of pressure score risk assessment to weekly to capture early detection of problems. We are reeducating the CNAs what they should look for when checking the resident's skin. We will use the Braden scale. Whenever the pressure sore risk assessment indicates a change in a problem, the care plan will be updated with interventions. A white board(WB) had been installed in the CNA office for all Nursing Home staff to use anytime there is a problem that needs to be communicated to the rest of the staff they will use the WB. Skin nurse will attend MDT meeting and report on every skin issues. (a) The "Daily Standup meeting" will be held in the CNA office to review the WB, Monday through Friday. The charge nurse will ensure that the process is followed throughout the weekend using the WB process and add to the Care Plan (b) The MDS coordinator/ Licensed staff/ IDT staff will agree on problems/goals/interventions that should be added to the Care Plans at that time with start and stop dates by them. All staff will be responsible to read and be aware of the Care Plans and failure to do so will result in disciplinary action by the DON.
			4.	The pressure sore risk assessment tool for each resident will be monitored each week for changes in risks and interventions for 3 months by the LPN on the skin team. Reported to QM monthly for three months .
			5.	COMPLETION DATE =4/7/15

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
F328	E	#6-9		Treatment/Care for Special Needs
			1.	On April 1, 2015 staff meeting, the licensed staff and CNA's were informed that only licensed staff can administer medications. That includes oxygen that is ordered by the physician, and must be on the care plan with the liter flow rate. Resident # 6,7 and 9 had oxygen added to their care plan with an order from the physician.
			2.	This could affect all residents who need oxygen per the wall or tank. All residents who are using oxygen --there were 13, had their care plans and orders checked to ensure that (a) there is an order by the doctor (b) that the order has a liter flow rate and (c) that it is in the care plan.
			3.	The MDS coordinator will change the oxygen tubing monthly and she will check each resident chart for a) an order by the doctor (b) that the order has a liter flow rate and (c) that it is in the care plan. If there is no order, the order will be obtained.
			4.	All residents who have oxygen will be monitored to ensure that: (a) there is an order by the doctor (b) that the order has a liter flow rate and (c) that it is in the care plan. This will be monitored in standup by the MDS coordinator daily X5, then weekly X 2 , then monthly X2 and reported to the DON.
			5.	COMPLETION DATE = 4/7/2015
F329	D	#2,5		Free from Unnecessary Drugs
			1.	April 1st 2015, the Licensed Staff were informed/ demonstrated the new practice to use CPSI to document effectiveness of narcotic pm pain medications as well as anti-anxiety medications that are given PRN. This will facilitate all residents including #2 and # 5 having their medications reevaluated for effectiveness.
			2.	All residents could be affected by this who receives PRN medications.
			3.	See #1 above.
			4.	The effectiveness charting will be monitored daily X 5 and then weekly X4 by a licensed nurse. If there are deficiencies the nurse will be counseled. The report will go to quality management monthly
			5.	COMPLETION DATE = 4/7/2015
F356	C	#1-9		Posting of Nurse Staffing
			1.	On April 1 st we informed the staff at staff meeting that daily nurse staffing must be posted for all shifts every day.
			2.	All residents will be affected by this
			3.	The night shift nurse/staff will post the number of RN, LPN and CNA's for the upcoming day for all shifts on the (daily nurse staffing) board located near the nurse's station. The unit secretary will also check to ensure it is posted. See #1 above
			4.	Day Shift Nurse will monitor on weekends and the ward clerk M-F to make sure that the board has been done Daily x 7, Weekly x 2, Monthly x1.
			5.	COMPLETION DATE =4/7/15
F368	E	8-12 Resident Council mtg		Frequency of HS snacks
			1.	We will discuss with the next resident council meeting and residents will be informed that all will be offered a HS snack every day.

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
			2.	All residents could be affected by this practice
			3.	April 1 st 2015, the CNA's were informed of the new practice of HS snacks for all residents.
			4.	All residents will be monitored for being offered or refused the offering of the HS snack. Using CPSI computer program using an AD HOC report, a CNA II will monitor every day for 14 days, every week for 2 weeks then once monthly x 1. Report will be given to quality management every month and reported quarterly
			5.	COMPLETION DATE = 4/7/15
F431	E	#13		Drug Records, Label/Store, Drug & Biological
			1.	Resident # 13 no longer a resident at the facility.
			2.	All residents could be affected by this.
			3.	April 1st 2015, the Licensed Staff were informed of the new practice from Pharmacy to: (a) Verify all medications brought into the facility (b) proper identification and labeling and (c) expiration date to prevent beyond use dating. The Licensed Staff were also informed that it is their responsibility check their medication carts, refrigerator, and medication storage area now, and every PM shift for: (d) when any multi -use medication is opened it is: (1) dated and (2) injectable medications will only be use for 28 days - this includes insulin (3) dated and if non sterile it can be used for 1 year not to extend beyond the manufacture's expiration date (e) all medications when the resident is discharged will either be sent home with the resident because they brought it in (f) all medications that are discontinued or the resident has expired will be sent to pharmacy. Single dose vials will removed from use and from the medication cart before the end of the shift that they were opened on.
			4.	Pharmacy will perform extensive checks and label all expiring medications with a label gun. They will do this once before 10th and then again in July to coincide with the annual review in Pharmacy (Jan and Jul) This will be an ongoing process and be reported to QM when it occurs with results of deficiencies. Licensed staff will fill out the report of their responsibilities (see #3 above) weekly X4 then monthly X3
			5.	COMPLETION DATE =4/7/15
F441	D	#1		Infection Control, Prevent Spread
			1.	On April 1, 2015 staff meeting with the licensed staff/ CNA's staff were informed of the survey results And that we did not follow our current policy of hand washing after removing PPE including gloves. That policy was reviewed with staff.
			2.	All residents could be affected by this
			3.	Automatic alcohol foam dispensers will be installed in all resident rooms. Additionally alcohol foam sanitizers in a can will be placed in some residents rooms, locked up, so health care providers can have portable access to alcohol hand rub.
			4.	Once a shift for days and evenings-for each cart - the LN will knock enter and observe ,a) that the removal of gloves is followed by using alcohol hand rub x 5 days, then twice a week x 3 week, then 5 x's random for days and afternoon shifts x one month.

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
			5.	COMPLETION DATE =4/7/15
F468	E	#2,8,9		Corridors' have firmly Secured Handrails
			1.	Handrails have been installed around the Spa in hallway A, to ensure that all residents have Handrails available to them for stability. See attached Photo
			2.	This could affect all residents. The facility has handrails along all other halls.
			3.	The Director of Nursing (DON) and Administrator will be notified on any construction affecting the handrails and availability of them to the residents.
			4.	The Handrails are installed and will be monitored for 3 days to ensure that stay in place by QM.
			5.	COMPLETION DATE = 4/7/15
F514	E	#8,9		Complete/Accurate/Accessible Records
			1.	Residents #8 and #9 had orders reviewed and updated as needed to meet the requirements of liter flow and PRN or continuous.
			2.	All charts of residents who had oxygen had their charts reviewed to ensure the orders were in the EMR correctly
			3.	The admission check list has been modified to alert admitting nurse to see if O2 order is required.
			4.	All new admissions for the next 3 months will have their orders reviewed to ensure if they have oxygen is in the (EMR) Medact correctly. QM coordinator will monitor and report to the DON and the QM committee monthly X 3 months
			5.	COMPLETION DATE = 4/7/15
F520	F	#1-9		Committee-Members/Meet Quarterly
			1.	The Quality Management (QM) committee members have been adjusted to reflect a physician on the committee. See attached new policy
			2.	All residents could be affected by this.
			3.	The Medical Staff was informed of the citation on 03-20-2015 and they chose a representative to attend Quality Management (QM) and Infection Control Committee (ICC) meetings monthly.
			4.	The QM meetings will be monitored monthly X 3 months by QM to ensure that physicians and other members are attending appropriately as required by law. See March 2015 and QM meetings .
			5.	COMPLETION DATE = 4/7/15
C664		#1-9		Infection Control Committee
			1.	The Infection Control committee members have been adjusted to reflect a physician on the committee. See new policy
			2.	All residents could be affected by this.
			3.	The Medical Staff was informed of the citation on 03-20-2015 and they chose a representative to attend Quality Management (QM) and Infection Control Committee (ICC)meetings monthly.
			4.	ICC meeting will be monitored monthly X 3 months by QM to ensure that physicians and other members are attending appropriately as required by law. See March 2015 of ICC and QM meetings attached.
			5.	COMPLETION DATE = 4/7/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The survey team included: Linda Kelly, RN, Team Coordinator, and Brad Perry, BSW, LSW.	C 000		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Infection Control Committee (ICC) attendance records and staff interview, it was determined the facility failed to ensure the Medical Director (MD) and Food Service Supervisor (FSS) participated in ICC meetings at least quarterly. The lack of participation of all ICC members created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included: On 3/11/15 at 3:45 p.m., the Quality Manager (QM) was interviewed about the facility's infection control program. The QM said she was the facility's Infection Preventionist. The QM said the ICC met monthly and that the DON, Administrator, Pharmacist, and housekeeping and maintenance staff attended and the ICC report was presented to the medical staff later. The QM was asked to provide the ICC attendance records since July 2014. On 3/12/15, the requested ICC attendance records were received. They were dated 7/11/14, 9/23/14, 10/28/14, 11/25/14, 12/23/14, and	C 664		

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 4/6/2015
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263
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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) COMPLETE DATE
C 664	<p>Continued From page 1</p> <p>1/27/15. Review of these records revealed that the MD and FSS had not attended any of the meetings.</p> <p>On 3/12/15 at 4:50 p.m., the Administrator and DON were informed of the issue. The facility did not provide any other information regarding the issue.</p>	C 664		