



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

March 25, 2015

Jason D. Jensen, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Mr. Jensen:

On **March 13, 2015**, a survey was conducted at Promontory Point Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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.) 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.

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.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

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

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

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

Jason D. Jensen, Administrator
March 25, 2015
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Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option 2, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **April 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,



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

NS/dmj
Enclosures

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2015
NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Lauren Hoard, RN, BSN</p> <p>The survey team entered the facility on 3/9/15 and exited on 3/13/15.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing HR = Heart Rate LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PO - By mouth PRN = As Needed RD = Registered Dietician RR = Respiratory Rate VS = Vital Signs WC = Wheelchair WNL = Within Normal Limits</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Promontory Point Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies".</p>	
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and</p>	F 156	<p>F 156</p> <p>1. All current patients were notified that they had the right to be fully informed of their</p>	

RECEIVED

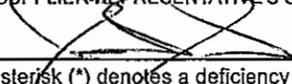
APR 21 2015

FACILITY STANDARDS

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

TITLE

(X6) DATE



Administrator

4/23/15

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

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F 156	<p>Continued From page 1</p> <p>regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including</p>	F 156	<p>health status in a language the resident could understand.</p> <p>2. All patients have the potential to be affected.</p> <p>A root cause analysis revealed that the previous admission agreement did not include the phrase in a language the resident could understand. The facility's admission agreement was updated with the resident's right to be fully informed of their health status in a language the resident could understand.</p> <p>3. The facilities admission agreement was reviewed and revised. The updated admission agreement will be given to all new patients being admitted to the facility.</p> <p>The admissions coordinator was educated on the changes to the admission agreement.</p> <p>4. Administrator or designee will conduct a random weekly audit on 3 new admission (or all admissions for the week if less than 3) per week for 4 weeks to</p>		

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F 156	<p>Continued From page 2</p> <p>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 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:</p>	F 156	<p>ensure that new residents were informed of their right to be fully informed of their health status in a language the resident could understand.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>		

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F 156	<p>Continued From page 3</p> <p>Based on review of the facility's Admission Agreement and staff interview, it was determined the facility failed to ensure residents knew of their right to be fully informed of their health status in a language the resident could understand. This deficient practice had the potential for harm should the facility admit a non-English speaking resident who did not understand their medical care. Findings included:</p> <p>The facility's Admission Agreement was reviewed on 3/11/15 as part of the standard survey process. The agreement did not include language informing residents of their right to be fully informed regarding their health status in a language the resident could understand.</p> <p>On 3/11/15 at 10:00 AM, the Administrator was asked to point out in the Admission Agreement the resident right to be fully informed regarding their health status in a language the resident could understand. After looking through the Admission Agreement with the surveyor and not finding the aforementioned resident's right, the Administrator said he would look into it further and contacted the Admissions Director.</p> <p>On 3/11/15 at 10:30 AM, the Admissions Director stated, "We do not currently have the language that states in a language the resident could understand, but I will change it to read in a language they can understand today." Later that day, the Admissions Director provided a copy of the page in the Admissions Packet which documented the resident right regarding their health status in a language the resident could understand.</p> <p>On 3/11/15 at 4:50 PM, the Administrator and</p>	F 156		

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F 156 F 157 SS=D	<p>Continued From page 4</p> <p>DON were informed of the concern with the Admission Agreement. No further information was provided by the facility.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 156 F 157	<p><u>F 157</u></p> <ol style="list-style-type: none"> 1. Patient #10 & 12 have discharged from the facility. 2. All patients have the potential to be affected. <p>A root cause analysis revealed that appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician were not being consistently conducted in regards to changes of condition including change in the color of urine and when a productive cough was noticed along with complaints of chest pain.</p> <ol style="list-style-type: none"> 3. The DON conducted a training on 3/31/15 in regards to the appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician were 	

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F 157	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on closed record review and staff interview, it was determined the facility did not ensure physicians were notified of changes when residents had a change in the color of their urine, or when a productive cough with reddish tinged sputum was first noticed along with complaints of chest pain. This was true for 2 of 2 (#s10 & 12) residents sampled. This deficient practice had the potential to cause more than minimal harm when the residents' physicians did not have the opportunity to evaluate these changes and initiate appropriate treatment. Findings included:</p> <p>1. Resident #12 was admitted to the facility on 6/4/14 and readmitted on 6/21/14 with multiple diagnoses which included rehabilitation, paraplegia, bladder cancer and acute cystitis.</p> <p>Review of the resident's Order Summary Report for June of 2014 documented the following orders with a start date of 6/4/14: *16 French foley catheter with 10 cc balloon. Change Q (every) month (on the 4th) and PRN and, *Foley cath care Q shift and PRN.</p> <p>Resident #12's care plan for indwelling catheter care, with a start date of 6/4/14, documented, "Note any changes in amount, frequency, color or odor. Report any abnormalities to Registered Staff."</p> <p>On 6/17/14 at 11:47 AM, a Progress Note (PN) documented the resident's foley catheter was in place with clear yellow colored urine. Later that day at 3:25 PM, a PN documented there was "...noted urine draining past foley catheter</p>	F 157	<p>not being conducted in regards to changes of condition including change in the color of urine and when a productive cough was noticed along with complaints of chest pain.</p> <p>The Change of Condition Policy and Procedure has been revised to outline the nurse responsibilities upon admission and throughout the residents stay.</p> <p>Education on the revised policy was conducted at the training on 3/31/15 by the DON.</p> <p>4. DON or designee will conduct a random weekly audit on 5 patients per week for 8 weeks for appropriate assessment, nursing diagnosis, planning and notification for evaluation and initiation of appropriate treatment by a physician in regards to changes of condition including change in the color of urine and when a productive cough was noticed along with complaints of chest pain.</p> <p>Areas of concern will be addressed immediately and</p>	

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F 157	<p>Continued From page 6 today...urine is brown/yellow in color. There was also dark brown mucous in the cath bag."</p> <p>No documentation was found in the resident's medical record the physician was informed of the change of the color of the urine from clear yellow to dark brown mucous.</p> <p>On 6/18/14 at 12:41 PM, a PN documented the resident's catheter was changed without difficulty and there was red tinged urine in the catheter bag. The resident's physician was notified, who reported to watch for complaints of fullness or clots and to notify the physician. The PN documented the resident had worked with therapy, became unresponsive with shallow breathing and was transported to a local hospital.</p> <p>The local hospital's Emergency Provider Report, dated 6/18/14 at 1:03 PM, documented in the Diagnosis, Assessment & Plan the resident had a syncopal event with no recurrence or lightheadedness in the hospital; dehydration and intravascular volume depletion; and, urinary tract infection, growing 40,000 colonies of enterococcus, and ID (identification of medication sensitivity) was pending. The report documented the resident was afebrile (did not have a fever), white count was down with recommendations to continue the Rocephin with the assumption it was sensitive to Ampicillin.</p> <p>On 3/12/15 at 3:50 PM, the DON was asked about the documentation in the 6/17 PN regarding the change in urine color from clear yellow to dark brown mucous. The DON stated the resident's physician should have been contacted, since she was seeing a urologist.</p>	F 157	<p>discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>		

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F 157	<p>Continued From page 7</p> <p>On 3/13/15 at 10:30 AM, the Administrator and DON were made aware of the concern with physician notification. No further information was provided by the facility.</p> <p>2. Resident #10 was admitted to the facility on 3/26/14 with multiple diagnoses which included diabetes, obesity and senile dementia.</p> <p>The most recent admission MDS assessment, dated 4/2/14, documented Resident #10 was rarely/never understood and unable to complete the mental status interview.</p> <p>Progress Notes for Resident #10 documented: * 4/15/14 at 8:30 PM - "Pt c/o [complains of] shortness of breath and coughing up a minimal amount of clear sputum with a reddish tinge after changing positions in bed and attempting to have a BM [bowel movement]. Pt's oxygen is 94% at this time while using 4.5L O2. Pt states he is not in any pain. Will continue to monitor pt." (The resident required an additional 2.5 L of O2); * 4/15/14 at 9:08 PM - "Pt states is 'feeling much better' and is no longer short of breath. Pt is still coughing but no longer has sputum at this time. Pt's oxygen sats are 90% on 4.5L per NC [Nasal Cannula]. Pt states he is comfortable and does not wish to take further action at this time. NOC [nighttime] nurse notified of pt's previous complaint, will continue to monitor. Pt states he will notify staff of any changes or concerns...;" * 4/16/14 at 1:17 PM - "...Lung sounds clear, patient continues to have quick short breathes.</p>	F 157		

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F 157	Continued From page 8 Continues to wear O2 at 2L per nasal canula [sic], sats above 90%...;" * 4/16/14 - "...2 rests d/t [due to] fatigue and SOB...;" * 4/16/14 at 10:15 PM - "Pt with productive cough this evening, sputum is clear with a pinkish tinge. Pt states he has been coughing throughout the day but that it was non-productive. Pt states he is not in pain at this time and has no difficulty breathing. Pt's VS: BP: 97/59, oxygen is 94% on 4L per NC, HR: 74, Temp: 97.1 oral, RR:16. Lung sounds were clear in all lobes bilat[erally] upon auscultation, somewhat diminished in bases. Notified [Physician's name] per fax, notified NOC nurse. Will continue to monitor pt and await new orders from [Physician's name]...;" * 4/21/14 at 10:13 PM - "Patient complaint of chest pain. Pt stated that he did not feel any pain in his left arm, but it did feel like someone was sitting on his chest. Pts vitals were taken BP:109/66 P [Pulse]:83 O2:95 [percent].Pt has had persistant cough throughout shift, which only seems to get better when sitting up. Pt was given cough medicine to relieve cough. Will continue to monitor pt;" * 4/23/14 at 10:47 PM - "Patient, after having been moved from the wheel chair [sic] to the bed experienced an episode of shortness of breth and difficulty breathing. Patient also stared off into the distance, seemingly looking nowhere in particular. During this phenomena patient was unresponsive and did not respond to questions asked. Patient would jerk a bit when touched on the arm. Patient became responsive after a few minutes, without any intervention. Patient then experieced [sic] the same episode after sitting upright in bed for a period of time. VS at this time were WNL [Within Normal Limits] and BG [Blood Glucose] 212. A few hours later patient repeated the same	F 157			

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F 157	Continued From page 9 process as before. Patient was asked if he would like to go to the hospital, patient declined. Daughter came to see patient. Daughter reported that patient's wife was going to come stay with patient. Patient wife and son came to see patient. Wife requested that we call the EMT's [Emergency Medical Technicians] and have him transferred to [local medical center]. Non-emergent transport notified. patient transferred to [local medical center] via ambulance, family followed patient to hospital in car. Called report into [local medical center] but patient had already arrived to hospital and report was declined;" and, * 4/24/14 at 5:05 AM - "Contacted ER [Emergency Room] department and staff states pt is being admitted." On 3/12/15 at 1:12 PM, the DON was interviewed regarding Resident #10 and his difficulty breathing and coughing. When asked what day the physician was notified of the resident's "reddish tinged sputum," she stated, "The next day," and he should have been notified, "right away." The DON was asked if the physician was notified of the resident's complaints of chest pain on 4/21/14, and she stated, "I'm not seeing anything." On 3/13/15 at 9:40 AM, the Administrator and DON were informed of the concerns with physician notification. No further information was provided.	F 157			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	<u>F 279</u> 1. Patient #2 and 6 have discharged from the facility.		

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F 279	<p>Continued From page 10 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure initial comprehensive care plans included interventions for insomnia, pressure ucler prevention, or toileting needs. This was true for 3 of 9 sampled residents (#s 2, 5 & 6) whose care plans were reviewed. This failure created the potential for residents' assessed needs not to be met due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 2/13/15 with multiple diagnoses which included aftercare of a knee joint replacement and insomnia.</p> <p>The most recent admission MDS assessment,</p>	F 279	<p>For patient #5's care plan was update for insomnia, pressure ulcer prevention. DON reviewed chart and 1:1 counseling of nurse involved.</p> <p>2. All residents have the potential to be affected.</p> <p>Root cause analysis revealed sufficient education regarding specifics of appropriate care planning and updating of care plans to include interventions was lacking.</p> <p>We believe that staffing education is the best prevention. All nursing staff will receive mandatory education on the assessment process and when and how to update the Care Plan. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes. From initial plan of care we have implemented a monitor of systemic changes including shift to shift change report specific to patient condition and care plan update documentation. All</p>	

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F 279	<p>Continued From page 11</p> <p>dated 2/20/15, documented Resident #2 was cognitively intact with a BIMS of 15 and received a hypnotic medication 7 days out of the preceding 7 days.</p> <p>Resident #2's Care Plan, initiated on 2/13/15, documented a focus of hypnotic therapy related to insomnia, and interventions which included not to exceed recommended daily dose thresholds for hypnotic medications and observation for possible side effects every shift.</p> <p>Resident #2's Care Plan did not include the intervention to monitor hours of sleep every night.</p> <p>Note: On 3/10/15 a copy of Resident #2's Care Plan was requested. Upon review of the care plan it was noted it contained the intervention to monitor hours of sleep every night, with the initiation date of 3/10/15. On 3/16/15 at 10:29 AM, the original Care Plan that did not contain the intervention was requested but not provided.</p> <p>The Order Summary Report for Resident #2 included an order, dated 2/13/15, which documented, "Monitor and document number of hours of sleep Q NOC [every night] one time a day."</p> <p>The March 2015 MAR for Resident #2 included the aforementioned order and documentation of the number of hours the resident slept.</p> <p>On 3/10/15 at 3:06 PM, the DON was asked if the hours of sleep were monitored for Resident #2, at which she stated, "Yes." When asked what the resident's care plan documented about it, the DON said, "It doesn't have it on there."</p>	F 279	<p>nursing Staff are required to perform a complete assessment of their patients. If staff are aware of what they are looking for then this will expedite the management of skin breakdown.</p> <p>Nursing staff were educated on properly updating patient care plans to include interventions used for insomnia, to prevent pressure ulcers, and incontinence care (toileting needs). Education provided on 3/31/15.</p> <p>3. We will maintain this by</p> <p>a. Nursing staff education to review patient medications and orders upon admission and with any new orders for hypnotics, new incidence of urinary incontinence, or anyone at risk for pressure ulcers. All patients that are identified are to be care planned accordingly for insomnia, pressure ulcer prevention, and incontinence care.</p> <p>b. All patients are to have a Braden scale upon admission and weekly thereafter for a total of 4 weeks. This will help</p>	

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F 279	<p>Continued From page 12</p> <p>2. Resident #6 was admitted to the facility on 1/19/15 with multiple diagnoses which included rehabilitation, history of falls, contusion of multiple sites and debility.</p> <p>The most recent admission MDS assessment, dated 2/2/15, documented the resident was cognitively intact, needed extensive assistance of one person for bed mobility, transfers, locomotion off and on the unit, dressing, toilet use and bathing. Additionally, the resident had impairment in functional limitation in range of motion on both sides, needed pain management and was at risk for developing pressure ulcers.</p> <p>The 2/2/15 MDS Assessment, Section V, Care Area Assessment (CAA) Summary, documented checkmarks in the triggered and care planned column for the problem of pressure ulcers.</p> <p>Review of Resident #6's clinical record did not include a care plan had been developed for the prevention of pressure ulcers.</p> <p>On 3/12/15 at 9:00 AM, the DON stated, "I do not see a care plan for pressure ulcers." When shown the CAA Summary which documented a care plan should have been developed, the DON states, "Yes, we should have a care plan for the prevention of pressure ulcers."</p> <p>3. Resident #5 was admitted to the facility on 1/8/15 with multiple diagnoses which included rehabilitation, general muscle weakness and bronchopneumonia.</p>	F 279	<p>identify patients at risk for skin breakdown.</p> <p>c. DON will review all new admission assessments, including Braden scale, orders and care plans to ensure proper interventions are in place.</p> <p>d. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes. Annual Competencies will be conducted during 4th quarter of the year.</p> <p>4. MDS coordinator will fill out and give to the DNS the CAA communication tool weekly. The DNS will use this form to verify that care plans have been completed for those CAA's triggered and needing to be care planned. DON or designee will conduct a random weekly audit on 4 patient care plans per week for 8 weeks, to ensure that comprehensive care plans have been updated to include interventions used for insomnia, to prevent pressure ulcers, and toileting needs.</p>	

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F 279	<p>Continued From page 13</p> <p>The most recent admission MDS assessment, dated 1/20/15, documented the resident had short term memory loss, frequent urinary incontinence, bowel incontinence, but was not on a toileting program. The resident needed extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene.</p> <p>The 1/20/15 MDS Assessment, Section V, Care Area Assessment (CAA) Summary, documented checkmarks in the triggered and care planned columns for Urinary Incontinence/Catheter and Dehydration - Fluid Maintenance.</p> <p>On 1/13/15 at 7:15 AM, the resident had a fall without injury and was placed on a toileting schedule.</p> <p>Review of Resident #5's clinical record did not include a care plan had been developed for Urinary Incontinence/Catheter or Dehydration - Fluid Maintenance as documented in the CAA Summary.</p> <p>On 3/12/15 at 9:25 AM, the DON was asked if the care plan for Resident #5 included urinary incontinence/catheter or dehydration - fluid maintenance which had triggered in the CAA Summary. The DON stated, "I don't see a care plan for incontinence or dehydration. The DON provided a copy of the toileting schedule for Resident #5. She stated the intervention had been added to the ADL Self Care Performance Care Plan but the resident did not have a care plan for urinary incontinence. When asked if a care plan should have been developed for a resident who was frequently incontinent and triggered for incontinence in the CAA Summary,</p>	F 279	<p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. Nursing meetings throughout year will address ongoing care planning education.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>		

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F 279	Continued From page 14 the DON stated, "Yes." On 3/12/15 at 5:20 AM the Administrator and DON were made aware of the concern with developing care plans as a result of the MDS Assessment. No further information was provided by the facility.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to review and revise care plans for 2 of 9 sampled residents (#s 5 & 6). Resident #5's care plan was not revised	F 280	<p>F 280</p> <p>1. Patient #6 has discharged from the facility.</p> <p>For patient #5's care plan was revised for current fall risk needs for safety. Care plan was updated by DON to reflect changes. DON spoke with patient regarding fall incident. 1:1 education provide by DON to nurse.</p> <p>2. All patients have the potential to be affected.</p> <p>Root cause analysis revealed sufficient education regarding specifics of appropriate care planning and updating of care plans to include interventions was lacking.</p> <p>We believe that staffing education is the best</p>	

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F 280	<p>Continued From page 15</p> <p>after the resident fell. Resident #6's care plan did not include non-pharmacological interventions for depression and was not revised after the resident fell. This had the potential for harm if residents did not receive the appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 1/8/15 with multiple diagnoses which included rehabilitation, general muscle weakness and bronchopneumonia.</p> <p>The most recent admission MDS assessment, dated 1/20/15, documented the resident had short term memory loss, frequent urinary incontinence, bowel incontinence, but was not on a toileting program. The resident needed extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene.</p> <p>An Incident Report, dated 1/13/15 at 7:15 AM, documented the resident fell, without injury, when he thought his wife was across the hall. The resident was noted to be incontinent and was placed on a scheduled toileting program.</p> <p>An Incident Report, dated 1/22/15 at 2:00 AM, documented the resident fell, without injury, when he moved too close to the edge of the bed and slid off. The resident was not reaching for anything or attempting to get up. Staff were educated that the resident's side rails needed to be down at night to help remind the resident of the edge of the bed.</p> <p>The facility's Fall Protocol documented to, "Update fall care plan with newly implemented interventions."</p>	F 280	<p>prevention. All nursing staff are required to update the patient care plans to include new interventions initiated post fall and care plan any interventions related to antidepressant medication therapy including non-pharmacological interventions. We will identify these patients by nurse to nurse report, DON review of all incident reports for falls, DON review of all new admission orders and care plans. DON or designee will review accident and incidents for the prior day.</p> <p>3. This will be maintained by:</p> <p>a. Nursing staff education to review patient medications and diagnoses upon admission and with any new order for antidepressant medication. All patients that are identified as having antidepressant medication therapy are to be care planned for depression including non-pharmacological interventions.</p> <p>b. Care plan library changes to now include non-pharmacological interventions to be personalized as needed.</p>		

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F 280	<p>Continued From page 16</p> <p>Resident #5's Fall Care Plan, initiated on 1/8/15, had not been revised since initiation and did not document the scheduled toileting program intervention or that side rails needed to be in the down position at night.</p> <p>On 3/12/15 at 9:25 AM, the DON was asked about the interventions added to Resident's 5's Fall Care Plan after the 1/13 and 1/22 falls. The DON stated, "There isn't any." When asked what should be on the care plan, the DON stated, "The new toileting schedule started on 1/13, and the side rails which need to be down at night. No, it isn't on the care plan."</p> <p>2. Resident #6 was admitted to the facility on 1/19/15 with multiple diagnoses which included rehabilitation, history of falls, contusion of multiple sites and debility.</p> <p>The most recent admission MDS assessment, dated 2/2/15, documented the resident was cognitively intact, needed extensive assistance of one person for bed mobility, transfers, locomotion off and on the unit, dressing, toilet use and bathing. Additionally, the resident had impairment in functional limitation in range of motion on both sides, needed pain management and was at risk for developing pressure ulcers.</p> <p>Resident #6's Order Summary Report documented a 2/5/15 order for Escitalopram Oxalate 10 mg one tablet by mouth daily for the diagnosis of depression.</p> <p>The resident's MAR, for the month of March 2015, documented the resident had received the medication daily and was monitored for signs and</p>	F 280	<p>c. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes. DON educated nursing staff on properly updating resident care plans to include interventions used for changes post fall and for non-pharmacological interventions for depression.</p> <p>d. Policy and procedure reviewed and updated to reflect any needed changes Education provided on 3/31/15.</p> <p>4. DON or designee will conduct weekly audits on 40% of admitted patients' care plans per week for 8 weeks, to ensure that comprehensive care plans have been updated to include interventions used post fall and for non-pharmacological interventions for depression.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. Nursing meetings throughout year will address</p>		

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F 280	<p>Continued From page 17 symptoms of depression.</p> <p>Review of the resident's care plan for depression, initiated on 2/5/15, did not include non-pharmacological interventions.</p> <p>An Incident Report, dated 2/28/15 at 7:15 PM, documented Resident #6 fell, without injury, when she attempted to self transfer from her WC to her bed and then used her call light. The resident was educated to use her call light when needing assistance. Physical Therapy (PT) was notified of the incident and planned to work with the resident on transfers with emphasis on locking her wheelchair brakes.</p> <p>Resident #6's Fall Care Plan, initiated on 1/20/15, had not been revised or updated since initiation.</p> <p>On 3/12/15 at 9:00 AM, the DON was asked if non-pharmacological interventions were used to help Resident #6 with depression. The DON stated, "We do not have non-pharmacological interventions. I'll check with the social worker." When asked about the Fall Care Plan interventions, the DON stated, "We didn't add anything to the resident's care plan under falls. We could have added no falls as a goal and could have added she had a fall with the date. Also, we could have added the PT evaluation, that they were working with the resident with an emphasis on transfers and locking WC brakes."</p> <p>On 3/12/15 at 5:10 PM, the Administrator and DON were made aware of the above mentioned care plan concerns. No further information was provided by the facility.</p>	F 280	<p>ongoing care planning education.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	<p><u>F 309</u></p> <p>1. Patient #8, 10, 11, and 12 have discharged from the facility.</p>		

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F 309 SS=G	<p>Continued From page 18 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure timely treatment was provided for a resident with a urinary tract infection (UTI) and residents with signs and symptoms of infection. This was true for 2 of 10 sampled residents (#s 10 & 8) and 2 of 2 random residents (#s 11 & 12). Resident #10 was harmed when staff failed to recognize signs and symptoms of pneumonia; the physician was not notified until the next day, and a chest x-ray was not done to rule out pneumonia. Additionally, the resident complained of chest pain, the physician was not notified, and the resident was sent to the emergency room with a resulting diagnosis of pneumonia. Resident #11 was harmed when he had blood tinged urine and pain at the catheter site and no treatment was provided. The resident was sent to the emergency room with a resulting diagnosis of urinary obstruction and sepsis. Resident #12 was harmed when the urine color changed from yellow to dark brown mucous, the physician was not notified and a urine analysis was not performed to rule out a UTI. The resident was transported to a local hospital the next day where she was diagnosed with a UTI and started on</p>	F 309	<p>2. All patients have the potential to be affected.</p> <p>Root cause analysis revealed sufficient education regarding timely notification of physician and treatment of residents with urinary tract infections and residents with signs and symptoms of infection was lacking.</p> <p>We believe that staffing education is the best prevention. All nursing staff are required to perform a complete assessment of their patients and notify the physician of any significant changes. If staff are aware of what they are looking for then this will expedite the prevention and management of infections. We will identify patients by utilization of the Interact Care Paths for symptom of lower respiratory infection or symptoms of a urinary tract infection, nurse to nurse report, review of nursing progress notes, and infection control tracking and trends. If trending found beyond normal</p>	

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F 309	<p>Continued From page 19</p> <p>antibiotics. Resident #8 had the potential for harm caused by a delay in treatment when the resident used her call light and told the CNA she was having trouble breathing. The nurse did not assess the resident but passed the information in her report to the oncoming nurse. Findings included:</p> <p>1. Resident #10 was admitted to the facility on 3/26/14 with multiple diagnoses which included diabetes, obesity and senile dementia.</p> <p>The most recent admission MDS assessment, dated 4/2/14, documented Resident #10 was rarely/never understood and unable to complete the mental status interview, required extensive assistance of 2 or more people for bed mobility and transfers, did not ambulate and had range of motion impairment to bilateral lower extremities.</p> <p>The following information for Resident #10 was gathered from Progress Notes (PN) and Physical Therapy Notes (PT) and were as follows: * (PT) 4/7/14 - "...Pt seems to be weaker today than he was yesterday. He required frequent rest breaks and was not able to perform exercises as well as he usually does. Pt recognized this and became a little discouraged. Pt was educated and reassured about the progress that he has made;" * (PT) 4/8/14 - "...he did not do as well today for standing tolerance. pt. had c/o [complained of] pain and fatigue;" * (PT) 4/9/14 - "...Pt very limited with transfers at this time, requiring 2 therapists for transfers, and CNA's on the hall are using the hoyer..." * (PT) 4/13/14 - "...Pt willing to try exercise, pt tolerated tx [treatment] well with multi[ple] rests due to SOB [shortness of breath];" * (PN) 4/14/14 at 12:01 PM - "...Lungs clear to all</p>	F 309	<p>standards, root cause analysis is reviewed at QA.</p> <p>Nursing staff were educated on properly notifying physician of patients showing signs and symptoms of infection including urinary tract infections. Also of notification to physician of complaints of chest pain, blood tinged urine, pain at the catheter site, change in the color or odor of urine, performing a UA to rule out UTI, and assessing patients with coughs and trouble breathing. Education provided on 3/31/15.</p> <p>3. This will be maintained by: a. Nursing staff education on assessment of signs and symptoms of UTI and lower respiratory infection with utilization of Care Paths also, education to awareness for patients at higher risk for development of UTI or lower respiratory infection. b. Additional education will be provided on and as needed basis for any noted infection control trends. c. Through our continued monitoring these processes will</p>	

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F 309	Continued From page 20 lobes...;" * (PT) 4/14/14 - "...he was very fatigue and did not do as well /c [with] standing activities...;" * (PN) 4/15/14 at 12:27 PM - "...Lung sounds clear, patient continues to have quick short breathes. Continues to wear O2 [Oxygen] at 2L [Liters] per nasal canula [sic], sats [saturations] above 90%." (NOTE: this was the first time oxygen was documented); * (PT) 4/15/14 - "...Discussed in detail with pt about his progress. Asked him what is [sic] plan is and he stated 'i have to be able to walk'. Asked him what the plan is if we don't get to that as it has been 3 wks [weeks] and no walking has been performed. His standing tolerance is still really struggling. He thinks we are doing everything we can to get him better, but it is very slow progress. Talked with SW [Social Worker] about pt as well;" * (PN) 4/15/14 at 8:30 PM - "Pt c/o [complains of] shortness of breath and coughing up a minimal amount of clear sputum with a reddish tinge after changing positions in bed and attempting to have a BM [bowel movement]. Pt's oxygen is 94% at this time while using 4.5L O2. Pt states he is not in any pain. Will continue to monitor pt." (The resident required an additional 2.5 L of O2); * (PN) 4/15/14 at 9:08 PM - "Pt states is 'feeling much better' and is no longer short of breath. Pt is still coughing but no longer has sputum at this time. Pt's oxygen sats are 90% on 4.5L per NC [Nasal Cannula]. Pt states he is comfortable and does not wish to take further action at this time. NOC [nighttime] nurse notified of pt's previous complaint, will continue to monitor. Pt states he will notify staff of any changes or concerns...;" * (PN) 4/16/14 at 1:17 PM - "...Lung sounds clear, patient continues to have quick short breathes. Continues to wear O2 at 2L per nasal canula [sic], sats above 90%...;"	F 309	be evaluated and any additional processes will be implemented to maintain our systemic changes. d. Policy and procedure reviewed/updated to reflect any needed changes. Education provided at staff meeting on 3/31/15 4. DON or designee will conduct weekly audits on 40% of admitted patients for 8 weeks. Audit will include looking for proper assessment, notification and timely treatment for signs and symptoms of infection, UTI, notification to physician of complaints of chest pain, blood tinged urine, pain at the catheter site, change in the color or odor of urine, performing UA to rule out UTI, and assessing patients with coughs and trouble breathing. . Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested.		

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F 309	<p>Continued From page 21</p> <p>* (PT) 4/16/14 - "...2 rests d/t [due to] fatigue and SOB...;"</p> <p>* (PN) 4/16/14 at 10:15 PM - "Pt with productive cough this evening, sputum is clear with a pinkish tinge. Pt states he has been coughing throughout the day but that it was non-productive. Pt states he is not in pain at this time and has no difficulty breathing. Pt's VS: BP: 97/59, oxygen is 94% on 4L per NC, HR: 74, Temp: 97.1 oral, RR:16. Lung sounds were clear in all lobes bilat[erally] upon auscultation, somewhat diminished in bases. Notified [Physician's name] per fax, notified NOC nurse. Will continue to monitor pt and await new orders from [Physician's name]...;"</p> <p>* (PN) 4/17/14 at 10:42 AM - "...Lung sounds clear to all lobes, patient continues to have quick short breathes. Continues to wear O2 at 2L per nasal canula [sic], sats above 90%...;"</p> <p>* 4/17/14 (PO) - Robitussin DM (Dextromethorphan-Gualfenesin) Syrup 100-10 MG/5ML by mouth for cough every 4 hours as needed;</p> <p>* (PT) 4/17/14 - "...pt able to perform ex[ercise] on his own but fatigues quickly /p [after] 5reps not able to complet[e] 10 reps in a row;"</p> <p>* (PT) 4/17/14 - "...he was very fatigued at end of treatment and required increased assistance for transfer;"</p> <p>* (PN) 4/18/14 at 8:32 AM - Robitussin administered;</p> <p>* (PN) 4/18/14 at 12:31 PM - "...Lung sounds clear to all lobes, patient continues to have quick short breathes. Continues to wear O2 at 2L per nasal canule [sic], sats above 90%...;"</p> <p>* (PN) 4/18/14 at 3:11 PM - Robitussin administered;</p> <p>* (PN) 4/18/14 at 8:52 PM - Robitussin administered;</p> <p>* (PT) 4/18/14 - "...Pt. very fatigued and struggled</p>	F 309	5. Date of Completion 4/16/15	

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F 309	<p>Continued From page 22</p> <p>to stay awake this afternoon...;"</p> <p>* (PN) 4/19/14 at 2:16 PM - Robitussin administered: "Patient requested for c/o cough;"</p> <p>* (PN) 4/19/14 at 4:01 PM - "Patient stated medication was effective;"</p> <p>* (PN) 4/19/14 at 8:26 PM - Robitussin administered: "pt requested for cough;"</p> <p>* (PT) 4/19/14 - "...he did fatigue easier today than he has during previous therapy sessions...Pt was disappointed that he couldn't do better today;"</p> <p>* (PN) 4/20/14 at 7:18 AM - Robitussin administered: "Patient requested for c/o cough;"</p> <p>* (PN) 4/20/14 at 8:53 AM - "Patient stated medication was effective;"</p> <p>* (PN) 4/20/14 at 2:33 PM - "...Lungs noted to be clear x4 lobes...;"</p> <p>* (PN) 4/20/14 at 8:32 PM - Robitussin administered: "given at pt request for c/o cough;"</p> <p>* (PN) 4/20/14 at 10:26 PM - "pt's cough has decreased;"</p> <p>* (PN) 4/21/14 at 12:26 PM - "...Lungs noted to be clear x4 lobes...;"</p> <p>* (PN) 4/21/14 at 7:55 PM - Robitussin administered: "Pt asked for cough medicine due to cough;"</p> <p>* (PN) 4/21/14 at 10:13 PM - "Patient complaint of chest pain. Pt stated that he did not feel any pain in his left arm, but it did feel like someone was sitting on his chest. Pts vitals were taken BP:109/66 P [Pulse]:83 O2:95 [percent].Pt has had persistent cough throughout shift, which only seems to get better when sitting up. Pt was given cough medicine to relieve cough. Will continue to monitor pt;"</p> <p>* (PT) 4/21/14 - "...Pt. required several interim rest breaks...;"</p> <p>* (PT) 4/21/14 - "...Pt fatigued easily with these exercises and required rest breaks between sets</p>	F 309		

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F 309	<p>Continued From page 23</p> <p>and exercises...Pt continues to fatigue easily with the exertion...;"</p> <p>* (PN) 4/22/14 at 12:55 AM - "Cough has decreased;"</p> <p>* (PN) 4/22/14 at 8:40 AM - Robitussin administered;</p> <p>* (PN) 4/22/14 at 10:37 AM - "...Lungs noted to be clear x4 lobes...;"</p> <p>* (PN) 4/22/14 at 5:16 PM - Robitussin administered;</p> <p>* (PN) 4/22/14 at 8:02 PM - Robitussin administered;</p> <p>* (PN) 4/22/14 at 11:01 PM - Robitussin administered: "Per pt request due to cough;"</p> <p>* (PT) 4/22/14 - "...Pt. very fatigued today, and had very low O2 levels, requiring frequent VC [Verbal Cues] to avoid deep breathing. Pt. unable to stand up complete;y [sic] d/t fatigue;"</p> <p>* (PT) 4/22/14 - "...needing rests secondary to SOB, fatigues quickly...Education given in pursed lip breathing /p education in breathing and following activity again, pt showing much improved O2 sats at 91%...;"</p> <p>* (PN) 4/23/14 at 11:07 AM - "...Lungs noted to be clear x4 lobes...Cough Syrup given with good results...;"</p> <p>* (PT) 4/23/14 - "...pt fatigued quickly and becomes SOB, many vc's for proper breathing techniques, pt tends to breath [sic] through his mouth and not his nose...Pt reports some SOB and fatigues during tx, pt on 4 L on O2, had difficulty time getting the oximeter to read correctly, measuring 75-85%, reported numbers to NSG [Nursing], also instructed pt in proper breathing technique..."</p> <p>* (PN) 4/23/14 at 10:47 PM - "Patient, after having been moved from the wheel chair [sic] to the bed experienced an episode of shortness of breath and difficulty breathing. Patient also stared</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>off into the distance, seemingly looking nowhere in particular. During this phenomena patient was unresponsive and did not respond to questions asked. Patient would jerk a bit when touched on the arm. Patient became responsive after a few minutes, without any intervention. Patient then experienced [sic] the same episode after sitting upright in bed for a period of time. VS at this time were WNL [Within Normal Limits] and BG [Blood Glucose] 212. A few hours later patient repeated the same process as before. Patient was asked if he would like to go to the hospital, patient declined. Daughter came to see patient. Daughter reported that patient's wife was going to come stay with patient. Patient wife and son came to see patient. Wife requested that we call the EMT's [Emergency Medical Technicians] and have him transferred to [local medical center]. Non-emergent transport notified. patient transferred to [local medical center] via ambulance, family followed patient to hospital in car. Called report into [local medical center] but patient had already arrived to hospital and report was declined;"</p> <p>* (PN) 4/24/14 at 5:05 AM - "Contacted ER [Emergency Room] department and staff states pt is being admitted."</p> <p>There was no documented evidence PT and Nursing had communication about Resident #10's symptoms.</p> <p>On 3/12/15 at 1:12 PM, the DON was asked what day the physician was notified of Resident #10's "reddish tinged sputum," and she stated, "The next day," He should have been notified, "right away." The DON was asked if the physician was notified of the resident's complaints of chest pain on 4/21/14, and she stated, "I'm not seeing</p>	F 309		

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F 309	<p>Continued From page 25 anything."</p> <p>There was a delay in treatment on 4/15/14 when Resident #10 had a productive cough with reddish tinged sputum and the physician was not notified until an order was received for cough syrup on 4/17/14, and on 4/21/14 when the resident complained of chest pain and the physician was not notified. This affected his ability to participate in therapy and discouraged the resident. Additionally, the resident continued to display symptoms of illness with no further physician notification or diagnostic work-up.</p> <p>2. Resident #11 was admitted to the facility on 4/14/14 with multiple diagnoses which included urinary obstruction and retention of urine.</p> <p>The Care Plan for Resident #11, dated 4/16/14, documented the resident had a suprapubic catheter related to obstructive uropathy. The interventions included monitoring for signs and symptoms of discomfort on urinary frequency, monitoring and documenting pain or discomfort due to the catheter, and monitoring/recording/reporting to physician signs and symptoms of a UTI such as pain and blood tinged urine.</p> <p>The following information was gathered for Resident #11 from Physician's Orders (PO), Progress Notes (PN) and a Fax Sheet (FS): * 4/14/14 at 2:43 PM (PN) - "...Pt was admitted...with the diagnosis obstructive uropathy...Pt has catheter in place with clear straw colored urine. Pt is alert to self only. Unable to determine year, place, or items about self such as if he wears dentures, allergies, last fall...;" * 4/16/14 (PO) - "Supra-pubic cath care Q [every]</p>	F 309		

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F 309	<p>Continued From page 26 shift and PRN;"</p> <p>* 4/21/14 (PO) - "UA [Urinary Analysis] microscopic/ C&S [Culture & Sensitivity] if indicated;"</p> <p>* 4/21/14 at 12:05 PM (PN) - "...Patient to see [Physician's name] this am. New orders for Levaquin 500mg po daily. Administered upon [sic] arrival [sic]. New orders for UA [Urinary analysis] collection, sent to lab, waiting for results. Patient to see [Urologist's name] this afternoon...cath site cleansed with NS gauze surrounding cath[eter]. Draining dark colored urine...;"</p> <p>* 4/21/14 at 10:30 PM (PN) - "Supra-pubic cath care Q shift and PRN. Pt would not comply to receive [sic] cath care. Will pass information on to next nurse to see if he will comply with the next nurse;"</p> <p>* 4/22/14 at 10:33 AM (PN) - "...New orders for Levaquin 500mg po daily...cath site cleansed with NS gauze surrounding cath. Draining dark amber colored urine...;"</p> <p>* 4/22/14 (PO) - "Urology Note: post op [operative] TURP [Transurethral Resection of the Prostate] [and] s-pubic [supra-pubic] cystotomy - Have asked nurses to clamp S-P tube and have him void - they will then open the S-P tube to measure residual urine volume;"</p> <p>* 4/23/14 at 11:04 AM (PN) - "Phoned [Urologist's name] office about pt. Pt is still incontinent. Tried to clamp off urinary [sic] tubing and pt would urinate in his pants. Pt has no clue when he needs to go. Waiting for new orders;"</p> <p>* 4/23/14 (PO) - "Check bladder residual twice a shift. Document ML residual and on 4-25-14 fax results to [Urologist's name];"</p> <p>* 4/25/14 at 8:12 PM (PN) - "...Pt has had blood tinged urine this evening, faxed information to [Physician's name], waiting for further orders. Bladder residual taken throughout shift,</p>	F 309		

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F 309	<p>Continued From page 27</p> <p>information faxed to [Physician's name], waiting for further orders..."</p> <p>* 4/25/14 (FS) - "Pt has blood tinged urine 4/25/14. Please inform of any new orders. Pt's urine residual today 4/25/14 was @ 0800 [8:00 AM] - 0 mL, @ 1200 [12:00 PM] - 1.5 mL[,] @ 1600 [4:00 PM] - 2 mL;"</p> <p>* 4/27/14 at 11:28 AM (PN) - "...Suprapubic catheter in place, draining amber colored urine. Patient encouraged [sic] to drink fluids and requires frequent reminders to drink. Fresh ice water provided and placed with in reach. Continues on levaquin daily for UTI. Patient denies suprapubic pain upon palpation..."</p> <p>* 4/27/14 at 6:35 PM (PN) - "Urine residual information sent via fax to [Urologist's name] 4/27/14. Waiting for further orders;"</p> <p>* 5/3/14 at 12:02 PM (PN) - "...Pts suprapub cath care done today and gauze dressing changed. Pt stated pain during change. Pt coughing today, cough is productive. Pt advised to sit up in bed to help with cough..."</p> <p>* 5/3/14 at 3:09 PM (PN) - "Levaquin order recieved [sic] today 5/3/14 from [Physician's name]...due to pts cough. Order placed in physicians orders;"</p> <p>* 5/4/14 at 10:54 AM (PN) - "Patient is drowsy [sic], disoriented to time, place, situation. Patient has expiratory wheezing...Heart rate iregular [sic]. While administering medications observed patient was clammy, red, and lethargic. Patient vitals WNL, temp was 101.7, patient window opened, jacket taken off, applied cold wash cloth to forehead. Patients granddaughter in room with patient. Reports 'This is how he was before he went to the hospital, I think he needs to go to the hospital now.' Encourage family to wait to reevaluate patient when patient is more awake and let tylenol take effect. Family verbalized</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>understanding. Patient assessed aprox [sic] 1 1/2hr later, patient continues to be very lethargic, unable to recognize granddaughter unble [sic] to answer questions appropriately. Agreed to send patient to ER, via facility van, family to meet patient there, MD notified, Paperwork sent with patient, Reports given to ER nurse...Will follow up;" and, * 5/4/14 at 6:31 PM (PN) - "Pt admitted to [local medical center] today 5/4/14 @ 1700 [5:00 PM] for UTI..."</p> <p>On 3/12/15 at 12:53 PM, the DON was interviewed about Resident #11. She said the resident had a UA done on 4/21/14 which came back positive for a UTI of Streptococcus agalactise, and was started on Levaquin for 7 days on 4/22/14. When asked about the physician's response to the fax regarding blood tinged urine, the DON said she was, "Not seeing anything." When asked about the physician's response to the urine residual information, the DON stated, "Judging from this [the computer system] there wasn't any" order or physician response. She said there was nothing indicating there was follow-up with the physician. The DON was asked when the physician should have been notified of the resident's signs and symptoms of infection displayed on 5/4/14, she stated, "Right away when they found them," and the nurse who waited 1.5 hours no longer worked in the facility.</p> <p>On 3/13/15 at 8:10 AM, the DON said generally if a resident was alert and was able to sit in the van, the facility van would transport the resident to the hospital, otherwise the non-emergent ambulance would be called. In the case of Resident #11, the DON did not know why the resident was transported via the facility van when he was not</p>	F 309		

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F 309	<p>Continued From page 29 alert or strong enough to do so.</p> <p>Resident #11 was harmed when he had blood tinged urine on 4/25/14, and the physician was notified with no response and treatment was not provided. The resident had pain at the catheter site on 5/2/14 and the physician was not notified and treatment was not provided. On 5/4/14, the resident displayed a temperature of 101.7, expiratory wheezes, disorientation, lethargy, was red and clammy, yet the LN waited 1.5 hours before sending the resident to the hospital and admitted for treatment of a UTI.</p> <p>On 3/13/15 at 9:40 AM, the Administrator and DON were informed of the delay in treatment concerns. No further information was provided.</p> <p>3. Resident #12 was admitted to the facility on 6/4/14 and readmitted on 6/21/14 with multiple diagnoses which included rehabilitation, paraplegia, bladder cancer and acute cystitis.</p> <p>The 6/11/14 admission MDS assessment documented the resident was cognitively intact, had lower extremity impairment on both sides and needed extensive assistance of 2+ persons for bed mobility, transfers, dressing and toileting.</p> <p>Review of the resident's Order Summary Report for June of 2014 documented the following orders with a start date of 6/4/14: *16 French foley catheter with 10 cc balloon. Change Q (every) month (on the 4th) and PRN and, *Foley cath care Q shift and PRN.</p> <p>Resident #12's care plan for indwelling catheter care, with a start date of 6/4/14, documented,</p>	F 309		

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F 309	<p>Continued From page 30</p> <p>"Note any changes in amount, frequency, color or odor. Report any abnormalities to Registered Staff."</p> <p>On 6/17/14 at 11:47 AM, a Progress Note (PN) documented the resident's foley catheter was in place with clear yellow colored urine. Later that day at 3:25 PM, a PN documented there was "...noted urine draining past foley catheter today...urine is brown/yellow in color. There was also dark brown mucous in the cath bag."</p> <p>NOTE: No documentation was found the foley catheter was changed or the physician was informed of the change of the color of the urine from clear yellow to dark brown mucous.</p> <p>On 6/18/14 at 12:41 PM, a PN documented, "...observed attend to be wet with urine/bloody discharge. Cath in place, changed catheter with 16F, without difficulty. Cath draining red tinged urine. Notified [name of physician]. Reports to watch if patient c/o [complained of] fullness, any clots noted to notify." The PN documented the resident had worked with therapy, became unresponsive with shallow breathing and was transported to a local hospital.</p> <p>The local hospital's Emergency Provider Report, dated 6/18/14 at 1:03 PM, documented in the Diagnosis, Assessment & Plan the resident had a syncopal event with no recurrence or lightheadedness in the hospital; dehydration and intravascular volume depletion; and, urinary tract infection, growing 40,000 colonies of enterococcus, and ID (identification of medication sensitivity) was pending. The report documented the resident was afebrile (did not have a fever), white count was down with recommendations to</p>	F 309		

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F 309	<p>Continued From page 31</p> <p>continue the Rocephin with the assumption it was sensitive to Ampicillin.</p> <p>The hospital discharge summary, dated 6/21/14, documented multiple final diagnoses which included urinary tract infection.</p> <p>On 3/12/15 at 3:50 PM, the DON was asked about the documentation in the 6/17 PN regarding the change in urine color from clear yellow to dark brown mucous. She stated it didn't look like a urine analysis had been done. When asked what should have been done, the DON stated she would have "expected staff to have changed the catheter or there could have been a clog in the catheter." When asked about flushing the catheter for clogs, the DON stated they would need a doctors order. When asked if they should have gotten an order to flush the catheter, the DON stated, "I would think so or change the catheter." The DON stated the resident's physician should have been contacted, since she was seeing a urologist. When asked if a urine analysis should have been done, the DON stated, "Yes."</p> <p>4. Resident #8 was admitted to the facility on 2/23/15 with diagnoses which included orthopedic aftercare, debility, and urinary tract infection.</p> <p>The resident's admission MDS assessment, dated 3/2/15, documented the resident was cognitively intact with a BIMS score of 15.</p> <p>On 3/11/15 at 4:10 PM, Resident #8 was observed in her room sitting in a lounge chair with her feet elevated. The resident was coughing and when questioned stated, "I coughed all night</p>	F 309		

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F 309	<p>Continued From page 32</p> <p>long." She stated she used her call light and when the CNA came in she told her, "I can't breathe, I'm just having trouble." The CNA told her she would tell the resident's nurse, but no one came in until around 7:00 AM. The resident stated she went to bed around 10:15 PM but couldn't sleep due to coughing. She stated she had to hold her chest because it felt heavy and it was hard to breathe. The resident stated she was placed on oxygen about 1:00 PM, which had helped her breathing and wished she would have been started on oxygen the previous night.</p> <p>On 3/11/15 at 4:25 PM, LN #3 stated she was told, by LN #4, in report this morning that Resident #8 was coughing last night. LN #3 stated when she checked on the resident that morning, her sats (saturations) were fine. However, the resident's sats dropped to 88% around 11:00 AM and crackles were noted in the resident's left lower lobe. She stated she obtained an oxygen order for 1-4 LPM (liters per minute) PRN to maintain oxygen saturation above 89%.</p> <p>No documentation by a nurse was found in the PN (Progress Notes) for the evening of 3/10/15 after 7:44 PM. No documentation by LN #4 was found in the PN for the evening shift of 3/10/15.</p> <p>On 3/12/15 at 8:15 AM, LN #3 stated the resident had started antibiotic therapy the previous night at 8:00 PM and would have a CXR (Chest X-Ray) that day. She stated the resident reported she felt better after being placed on oxygen and her cough had decreased.</p> <p>On 3/12/15 at 10:30 AM, the DON stated she had some issues with LN #4's documentation, which she felt was lacking, and had discussed her</p>	F 309		

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F 309	<p>Continued From page 33</p> <p>concerns with LN #4 several times. When told about the lack of documentation for the evening shift on 3/10, the evening LN #4 worked, the DON stated, "That's my issue, her not documenting things, as in this case."</p> <p>Resident #8 was observed to continue coughing throughout the survey process on 3/12/15 at 11:30 AM, 1:15 PM and 3:00 PM.</p> <p>On 3/12/15 at 3:15 PM, LN #3 called the local hospital to obtain findings of the CXR taken that morning. LN #3 stated the technician told her the X-Ray looked fine and she would fax over the results. The Radiology report documented the X-Ray was taken on 3/12/15 at 10:15 AM, and, "Marked hyperinflation of the lungs is noted along with maybe emphysematous changes in the lungs. There are no foci of consolidation. There is no evidence of an acute inflammatory or infectious process."</p> <p>On 3/13/15 at 9:00 AM and 10:00 AM, Resident #8 was observed to continue coughing.</p> <p>On 3/13/15 at 8:40 AM, the DON provided signed statements from LN #4 and CNA #5, night shift staff who worked 3/10/15 on the resident's hall. However, this information did not resolve the concern related to delay of treatment.</p> <p>On 3/13/15 at 10:30 AM, the Administrator and DON were made aware of the above mentioned concerns. No further information was provided by the facility.</p>	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	<p>Continued From page 34</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, Policy & Procedure review and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent the development of pressure ulcers. This was true for 1 of 10 (#10) sampled residents. This deficient practice created the potential for more than minimal harm when the facility failed to implement preventative measures and a resident developed a Stage II pressure ulcer. Findings included:</p> <p>The facility's Comprehensive Admission Skin Assessment Policy, revised 8/2008, documented, "...3...Although a patient may be assessed to be 'no risk' or 'low risk' per the Braden Scale Assessment, the individual areas of the Braden scale should be considered when developing interventions and care plan...The care plan is updated whenever a resident has a change in condition either progression or regression. Care plans must be updated no more than 72 hours after change in condition occurs...5. Identified skin areas should have weekly documentation using the wound/skin healing assessment that includes measurements and how the wound is progressing towards healing...7. When a wound</p>	F 314	<p><u>F 314</u></p> <ol style="list-style-type: none"> 1. Patient #10 discharged from the facility. 2. All patients have the potential to be affected. <p>A root cause analysis revealed appropriate assessment, nursing diagnosis, planning, implementation, and evaluation were lacking in regards to skin integrity.</p> <p>We believe that staffing education is the best prevention. All nursing staff are required to perform a complete assessment of their patients and notify the physician of any significant changes. If staff are aware of what they are looking for then this will expedite management of skin breakdown. We will identify these patients by DON review of all new admission assessments, orders, and care plans, including Braden Scale; DON review of all incident reports for new skin issues; nurse to nurse report; and</p>	

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F 314	<p>Continued From page 35</p> <p>develops and is identified through skin checks or routine care, procedures should include the following: a. Nurse examines the wound...and completes...a skin assessment...d. An assessment/investigation...that assesses how this happened, and identification of the type of ulcer it is and what are plan interventions now need to be implemented, if any to prevent further problems...8. Weekly analysis performed by the DON to assess progress towards healing of the new wounds in the facility..."</p> <p>Resident #10 was admitted on 3/26/14 with multiple diagnoses which included diabetes, obesity and senile dementia.</p> <p>The most recent admission MDS assessment, dated 4/2/14, documented Resident #10 was rarely/never understood and unable to complete the mental status interview, did not display behaviors, required extensive assistance of 2 people or more for bed mobility and transfers, did not ambulate, had range of motion impairments to his bilateral lower extremities and did not have any unhealed pressure ulcers or diabetic foot ulcers.</p> <p>A Nursing Admission Assessment, dated 3/26/14, documented Resident #10 had a "discolored area" to the right buttock measuring 3.5 cm x 4 cm with no depth.</p> <p>Resident #10 had three Braden Scale for Predicting Pressure Ulcer Risk assessments and were as follows: * 4/2/14 - Low risk with a score of 17.0; * 4/9/14 - Low risk with a score of 15.0; and, * 4/16/14 - Low risk with a score of 16.0.</p>	F 314	<p>review of skin care report cards as utilized by direct care staff.</p> <p>Nursing staff were educated on the Dermarite skin protocol, Comprehensive Admission Skin Assessment Policy and Procedure, Pressure Ulcer Treatment Policy and Procedure These policies were review and updated as needed. Education provided at staff meeting on 3/31/15.</p> <p>3. We will maintain this by a. Nursing education with emphasis of prevention with awareness b. Policy change with staff orientation upon hire and annual competency skill pass off c. Staff education to Braden scale which includes awareness for high risk patients such as preventing pressure ulcers with devices, high use toileting needs, skin breakdown indication upon assessment, repetitive or high frequency movement that may result in skin breakdown, skin pathway management for high risk patient.</p>	

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F 314	Continued From page 36 An Incident Report, dated 4/6/14, documented the description, "Upon taking Pt [Patient] TED hose off, a blister was noted to Pt left heel. The blister measures approx.[imately] 4.5cm x 6.2cm and is intact, peri-wound area noted to have some non-blanching redness toward posterior heel. Pt states he didn't even know it was there, he states there is no pain. Pt states it might be because he sits in his chair and slides his feet back and forth to straighten his legs and bend them to get comfortable." The Immediate Action taken documented, "The area was measured, cleansed and dressed with skin prep and a bordered gauze. [Physician's name] notified of new skin issue, orders received to treat as necessary and call with complications. Pt spouse was notified of issue. Pt educated to avoid sliding heels on the carpet. Pt states it [sic] hard because of the pain in his knees. Pt educated to elevate feet while up in chair, Pt refused stating that it is not comfortable. Pt then educated to lay down during the day for brief periods to help relieve some pressure to the area, Pt states he does not like to lay down during the day. The Pt was educated on the risks of not relieving pressure to the area and refusing interventions. Pt verbalized understanding. Pt is alert and oriented x3. Pt spouse reports that he has had trouble with that heel in the past. The pt does not wear any shoes or slippers, he just wears his non-slip socks. The pt also has a wound surface mattress/bed...d/t [due to] his height. We will refrain from putting Pt TED hose on that leg to avoid any friction it may cause during don/doff of the TED hose. We will monitor the area closely and notify the physician of any immediate concerns." The following information was gathered from	F 314	d. All patients that are identified as high skin breakdown risk or identified to have a new skin issue as reported by the skin care report card require a review by second nurse and provider notification. e. Director of nursing will review patients with high and low skin risks on a random basis. f. All patients are to have a Braden scale done upon admission and weekly thereafter for a total of 4 weeks g. If any deviation from skin management pathway an occurrence report will be filled out and DON will review on case by case basis with QA committee to approve plan of correction for staff and process. 4. DON or designee will conduct weekly audits on 40% of admitted patients' skin assessments for 8 weeks, who are at risk for skin issues (who are moderate to high risk on the Braden scale). The audit will ensure proper interventions in place to meet the patient's condition. Weekly nutrition at risk meetings with the interdisciplinary team, which		

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F 314	Continued From page 37 Physician's Orders (PO), Care Plan (CP), Wound/Skin Healing Assessment (WHA), Progress Notes (PN), Physical Therapy Notes (PT) and Wound Clinic Notes (WC): * 3/26/14 (PO) - "Weekly skin check - document on progress note;" * 4/1/14 (PO) - "Low air loss mattress to offload pressure and promote skin integrity;" * 4/6/14 (PN) - "Upon removal of TED hoes, Pt left heel is bruised possibly blistered. Skin is non-blanchable. Contacted [LN's name] to inform him if [sic] pt condition. Border guaze [sic] placed on Left heel. Pt reports no pain at this time, no furhter [sic] issues needed at this time...;" * 4/8/14 (PN) - "Weekly skin check - document on progress note: Skin check completed, open blister noted to R[ight] heel, DON aware..." (Note: Right heel was incorrect); * 4/11/14 (PT) - "...Pt was lim[ited] by significant R knee pain and NWB [Non-Weight Bearing] precautions on L heel d/t open wound...Pt's wound on L heel has no opened and NWB on the L heel, although no physician's orders have been received for this change in WB status;" * 4/12/14 (PN) - "...large blister in L[eft] heel. dressing changed, no s/s [signs and symptoms] of infx [infection] scant serous drainage...;" * 4/14/14 (CP) - Focus, "Pressure ulcer stage II to left heel R/T [Related To] immobility and Diabetes. Interventions, "...turn/reposition at least every 2 hours, more often as needed or requested; Administer treatments as ordered and monitor for effectiveness; He uses (2) 1/4 side rails to assist with turning while in bed; Left Heel PU [Pressure Ulcer]: Cleanse with NS [Normal Saline] skin prep surrounding tissue, cover with optifoam. Change dressing QD [Every day] and PRN for dressing failure [revised on 4/16/14]; Weekly skin check - document on progress note;"	F 314	includes the DON and RD and others as needed, will review Braden scales and any new identified skin issues. Wound specific care plans will be reviewed for accuracy and proper EMR dates reflecting addition of all new interventions. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested. 5. Date of Completion 4/16/15	

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F 314	<p>Continued From page 38</p> <p>* 4/15/14 (PN) - "...R heel dressing changed. area is beefy red with small dark area on the edge. Notified wound care nurse. Will be looked at again this afternoon;"</p> <p>* 4/15/14 (PN) - "Pt's bandage on left heel changed d/t inadequate adhesion. Area cleansed with gauze and NS, wound surrounded with sureprep skin wipe, optifoam applied. Wound did not have any foul odor, pt states is not painful. No redness noted, minimal serosanguinous [sic] drainage noted...;"</p> <p>* 4/16/14 (CP) - "Low air loss mattress to offload pressure and promote skin integrity;"</p> <p>* 4/16/14 (PN) - "...R heel dressing changed. area is beefy red with covered with eschar. Pressure sore is unstagable [sic] at this time. dark area on the edge. [DON] notified of change in wound. PT education done with patient to keep pressure off of the heels...;"</p> <p>* 4/16/14 (PN) - "IDT Nutrition Meeting r/t pt with new pu to left heel (3.2cm x 4.5cm)...Current nutrition plan and meal intakes adequate to aid in wound healing and skin integrity...Review for skin monitoring in IDT x 2weeks [sic];"</p> <p>* 4/17/14 (PN) - "Pt dressing changed to left heel. Blistered area is now opened. Wound bed is granular with a small amount of slough. Pt denies pain. New dressing orders received. Pt educated on elevating his feet while up in his chair again and agreed this time...;"</p> <p>* 4/17/14 (WHA) - Left heel pressure measuring 6.2 cm x 4.5 cm x 0.1 cm at a Stage III. Wound bed with granulation tissue and slough, surrounding skin macerated. "Blistered area is now open, wound bed is granular, Pt denies pain. New dressing ordered-dermanet AG and optifoam. Pt agreed to elevate legs while in chair."</p> <p>* 4/17/14 (PO) - "Left Heel pressure ulcer:</p>	F 314		

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F 314	<p>Continued From page 39</p> <p>Complete new 'Wound/Skin Healing' assessment Q [every] week until resolved;"</p> <p>* 4/17/14 (PO) - "Left Heel: Cleanse with normal saline, skin prep surrounding tissue, cover with maxorb AG and optifoam. Change dressing Q3 Days and PRN for dressing failure;"</p> <p>* 4/20/14 (PN) - "...Dressing changed to left heel per MD order. No s/sx of infection noted. Noted when patient sits up her [sic] prefers to stretch his legs out and rest his feet upon his heels, noted patient sliding his heels across [sic] the floor to reposition in wheelchair. Education provided to patient about using call light and notifying staff is [sic] he needs assistance with repositioning as to not place friction to heels while trying to reposition. Patient verbalized understanding of education, will continue to monitor...;"</p> <p>* 4/21/14 (PO) - "Podus boot to left foot as resident allows;"</p> <p>* 4/21/14 (CP) - "Podus boot to left foot as resident allows to offload pressure;"</p> <p>* 4/21/14 (PO) - "Remove podus boot and check skin integrity four times daily;"</p> <p>* 4/22/14 (PN) - "...Encourage patient to elevate extremities [sic], Currently resting in room with feet elevated, podus boot removed and skin checked. no new issues...;"</p> <p>* 4/22/14 (PN) - "Pt dressing changed to pressure ulcer on left heel. PU measuring 5.4cm x 5.6cm x 0.1cm. Moderate amount of serosang drainage noted. Wound is slightly malodorous and periwound in [sic] slightly macerated. Wound bed is granular with a dark area approx. 1.5cm x 2cm toward the upper left wound bed (approx. 10 o'clock). Wound was cleansed with NS, skin prep applied to periwound, dressing applied per MD orders. Pt cont[inues] to wear podus boot to left foot with nursing removing to check skin integrity 4 times daily. Pt also con on ...wound surface</p>	F 314		

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F 314	<p>Continued From page 40</p> <p>bed. Pt re-educated again to elevate feet while up in chair and call for assistance if he needs to reposition. Pt has an appt [appointment] with [local medical center A] wound care on Thursday, 4/24/14 @ 0900 [9:00 AM]. Per Pt request we will try to get Pt in to [local medical center B] wound care instead. Will f/u [follow-up] with [local medical center B] wound care for appt;"</p> <p>* 4/22/14 (PO) - "Pt to [wound care center] on 4/23/14 @ 0800 [8:00 AM];"</p> <p>* 4/23/14 (PN) - "...Encourage pt to elevate extremities [sic], Currently resting in room with feet elevated, podus boot removed and skin checked. no new issues. Pt to [local medical center B] Wound Care for pressure sore on L Heel. Awaiting orders...;" and,</p> <p>* 4/23/14 (WC) - "...Approximately 3 weeks ago he developed a blister on the the [sic] left heel presumably from pressure while at [the facility]...The Stage II pressure ulcer located on the left heel has been present for approximately 14 days. The pressure ulcer is thought to be related to immobility. The pressure ulcer measures 6.5 cm x 4 cm x 0.3 cm. The patient scores the pain as 3 on a scale of 0 to 10. There is a minimum amount of serosanguinous exudate draining from the pressure ulcer. The pressure ulcer bed has exposed partial thickness and eschar tissue. The skin around the pressure ulcer is epithelizing and edematous...The pressure ulcer does not show signs of symptoms of infection...Pain Assessment...Status worsening; Duration three weeks; Causes/Aggravates standing..."</p> <p>On 3/12/15 at 1:12 PM, the DON was interviewed about Resident #10 and the pressure ulcer. She said the interventions in place to prevent pressure ulcers included a low air loss mattress, due to the</p>	F 314			

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F 314	Continued From page 41 resident's height on 4/1/14, and weekly skin assessments. The DON said the Wound/Skin Healing Assessments were initiated, "Once a problem is identified," and there was not a WHA for the blister noted on 4/6/14 because the assessment was included with the incident report. The DON was asked when the blister opened, and she stated, "The 17th [of April 2014]." After the surveyor informed the DON it had opened prior to that date, she reviewed progress notes and stated, "The 15th [of April 2014]." When asked about the pressure ulcer staging, she said it was a Stage III by definition with some slough in the wound. The DON was asked why 11 days went by before another WHA was done, and she stated, "I do not know why. There should have been one done on the 13th [of April 2014]." Resident #10 developed a pressure ulcer while residing in the facility. Per the Wound Clinic it was a Stage II, but per the facility it was a Stage III. The only preventative interventions in place were the air mattress and weekly skin checks, and the skin care plan was not initiated until 4/14/14, 7 days after the resident developed the pressure ulcer. The blister opened 4 days after it was noted, on 4/8/14, but further assessments were not completed for another 9 days, on 4/17/14. In addition, Progress Notes documented the resident was to utilize his call bell to be repositioned, despite his diagnosis of senile dementia. On 3/12/15 at 5:10 PM, the Administrator and DON were informed of the pressure ulcer concerns. No further information was provided.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	<p>Continued From page 42</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents with urinary catheters received necessary care and services to prevent urinary tract infections. This was true for 2 of 2 (#s 11 & 12) sampled residents. Resident #11 was harmed when he was not provided treatment and was admitted to the hospital with urinary obstruction, sepsis and dehydration. Resident #12 was harmed when she developed a urinary tract infection in the facility which was diagnosed at a local hospital's emergency room. Findings included:</p> <p>1. Resident #12 was admitted to the facility on 6/4/14 and readmitted on 6/21/14 with multiple diagnoses which included rehabilitation, paraplegia, bladder cancer and acute cystitis.</p> <p>The 6/11/14 admission MDS assessment documented the resident was cognitively intact, had lower extremity impairment on both sides and needed extensive assistance of 2+ persons for bed mobility, transfers, dressing and toileting.</p>	F 315	<p><u>F 315</u></p> <p>1. Patient #11 and 12 discharged from the facility.</p> <p>2. All patients with urinary catheters have the potential to be affected.</p> <p>A root cause analysis revealed appropriate assessment, nursing diagnosis, planning, communication to physician, implementation, and evaluation were not conducted in regards to changes with patients having urinary catheters.</p> <p>We believe that staffing education is the best prevention. All nursing staff are required to perform a complete assessment of their patients and notify the physician of any significant changes. If staff are aware of what they are looking for then this will expedite the prevention and management of infections. We will identify these patients by utilization of the Interact Care Paths for symptoms of a urinary tract infection, nurse to nurse report, review of nursing progress</p>	

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F 315	<p>Continued From page 43</p> <p>Review of the resident's Order Summary Report for June of 2014 documented the following orders with a start date of 6/4/14: *16 French foley catheter with 10 cc balloon. Change Q (every) month (on the 4th) and PRN and, *Foley cath care Q shift and PRN.</p> <p>Resident #12's care plan for indwelling catheter care, with a start date of 6/4/14, documented, "Note any changes in amount, frequency, color or odor. Report any abnormalities to Registered Staff."</p> <p>On 6/17/14 at 11:47 AM, a Progress Note (PN) documented the resident's foley catheter was in place with clear yellow colored urine. Later that day at 3:25 PM, a PN documented there was "...noted urine draining past foley catheter today...urine is brown/yellow in color. There was also dark brown mucous in the cath bag." There was no documentation was found the foley catheter was changed or the physician was informed of the change of the color of the urine from clear yellow to dark brown mucous.</p> <p>On 6/18/14 at 12:41 PM, a PN documented, "...observed attend to be wet with urine/bloody discharge. Cath in place, changed catheter with 16F, without difficulty. Cath draining red tinged urine. Notified [name of physician]. The PN documented the resident became unresponsive with shallow breathing and was transported to a local hospital.</p> <p>The local hospital's Emergency Provider Report, dated 6/18/14 at 1:03 PM, documented in the Diagnosis, Assessment & Plan the resident had</p>	F 315	<p>notes, and infection control tracking and trends.</p> <p>Nursing staff were educated on timely notification of the physician to patient's changes in urine color, odor, frequency, and performing UA's on patients with urinary catheters. Education provided at staff meeting on 3/31/15.</p> <p>3. This will be maintained by: a. Nursing staff education on assessment of signs and symptoms of UTI with utilization of Care Paths. In addition, education to awareness for patients at higher risk for development of UTI. b. Additional education will be provided on an as needed basis for any noted infection control trends. c. Nursing staff will be required to document every shift if there are any changes in urine color, odor, output, or consistency in patients with urinary catheters. Notify physician of these changes. Any deviation from the care path will be reviewed on a case by case basis by the DON with QA committee to</p>		

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F 315	<p>Continued From page 44 multiple acute medical issues, including a UTI. Please see F 309 for details.</p> <p>On 3/12/15 at 3:50 PM, the DON was asked about the documentation in the 6/17 PN regarding the change in urine color from clear yellow to dark brown mucous. She stated it didn't look like a urine analysis had been done. When asked what should have been done, the DON stated she would have, "expected staff to have changed the catheter or there could have been a clog in the catheter." When asked about flushing the catheter for clogs, the DON stated they would need a doctors order. When asked if they should have gotten an order to flush the catheter, the DON stated, "I would think so or change the catheter." The DON stated the resident's physician should have been contacted, since she was seeing a urologist. When asked if a urine analysis should have been done, the DON stated, "Yes."</p> <p>On 3/13/15 at 10:30 AM, the Administrator and DON were made aware of the above mentioned concerns. No further information was provided by the facility.</p> <p>2. Resident #11 was admitted to the facility on 4/14/14 with multiple diagnoses which included urinary obstruction and retention of urine.</p> <p>The Care Plan for Resident #11, dated 4/16/14,</p>	F 315	<p>approve plan of correction for staff and process.</p> <p>d. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes.</p> <p>4. DON or designee will conduct weekly audits on all patients admitted with urinary catheters for 8 weeks for notification of the physician, per care path, to patient's changes in urine color, odor, output or consistency and performing UA's on these patients if necessary.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>	

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F 315	<p>Continued From page 45</p> <p>documented the resident had a suprapubic catheter related to obstructive uropathy. The interventions included monitoring for signs and symptoms of discomfort on urinary frequency, monitoring and documenting pain or discomfort due to the catheter, and monitoring/recording/reporting to physician signs and symptoms of a UTI such as pain and blood tinged urine.</p> <p>Please see F 309 as it pertains to changes in the resident's urinary status, development of a UTI, and the timeliness of the physician's reponse.</p> <p>The following information was gathered for Resident #11 from Physician's Orders (PO), Progress Notes (PN) and Fax Sheet (FS):</p> <ul style="list-style-type: none"> * 4/14/14 at 2:43 PM (PN) - "...Pt has catheter in place with clear straw colored urine. Pt is alert to self only..." * 4/16/14 (PO) - "Supra-pubic cath care Q [every] shift and PRN;" * 4/21/14 at 12:05 PM (PN) - "...Patient to see [Physician's name] this am. New orders for Levaquin 500mg po daily. New orders for UA [Urinary analysis] collection, sent to lab, waiting for results. Patient to see [Urologist's name] this afternoon...cath site cleansed with NS gauze surrounding cath[ether]. Draining dark colored urine...;" * 4/21/14 at 10:30 PM (PN) - "Supra-pubic cath care Q shift and PRN. Pt would not comply to recieve [sic] cath care. Will pass information on to next nurse to see if he will comply with the next nurse;" * 4/22/14 at 10:33 AM (PN) - "...New orders for Levaquin 500mg po daily...cath site cleansed with NS gauze surrounding cath. Draining dark amber colored urine...;" 	F 315		

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F 315	<p>Continued From page 46</p> <p>* 4/22/14 (PO) - "Urology Note: post op [operative] TURP [Transurethral Resection of the Prostate] [and] s-pubic [supra-pubic] cystotomy - Have asked nurses to clamp S-P tube and have him void - they will then open the S-P tube to measure residual urine volume;"</p> <p>* 4/23/14 at 11:04 AM (PN) - "Phoned [Urologist's name] office about pt. Pt is still incontinent. Tried to clamp off urinary tubing and pt would urinate in his pants. Pt has no clue when he needs to go. Waiting for new orders;"</p> <p>* 4/25/14 at 8:12 PM (PN) - "...Pt has had blood tinged urine this evening, faxed information to [Physician's name], waiting for further orders. Bladder residual taken throughout shift, information faxed to [Physician's name]..."</p> <p>* 4/25/14 (FS) - "Pt has blood tinged urine 4/25/14. Please inform of any new orders. Pt's urine residual today 4/25/14 was @ 0800 [8:00 AM] - 0 mL, @ 1200 [12:00 PM] - 1.5 mL[,] @ 1600 [4:00 PM] - 2 mL;"</p> <p>* 4/27/14 at 11:28 AM (PN) - "...Suprapubic catheter in place, draining amber colored urine. Patient encouraged [sic] to drink fluids and requires frequent reminders to drink. Fresh ice water provided and placed with in reach. Continues on levaquin daily for UTI. Patient denies suprapubic pain upon palpation..."</p> <p>* 4/27/14 at 6:35 PM (PN) - "Urine residual information sent via fax to [Urologist's name] 4/27/14. Waiting for further orders;"</p> <p>* 5/3/14 at 12:02 PM (PN) - "...Pts suprapub cath care done today and gauze dressing changed. Pt stated pain during change. Pt coughing today, cough is productive. Pt advised to sit up in bed to help with cough..."</p> <p>* 5/3/14 at 3:09 PM (PN) - "Levaquin order recieved [sic] today 5/3/14 from [Physician's name]...due to pts cough. Order placed in</p>	F 315		

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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406		
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F 315	<p>Continued From page 47</p> <p>physicians orders;"</p> <p>* 5/4/14 at 10:54 AM (PN) - "Patient is drowsy [sic], disoriented to time, place, situation. Patient has expiratory wheezing...Heart rate iregular [sic]. While administering medications observed patient was clammy, red, and lethargic. Patient vitals WNL, temp was 101.7, patient window opened, jacket taken off, applied cold wash cloth to forehead. Patients granddaughter in room with patient. Reports 'This is how he was before he went to the hospital, I think he needs to go to the hospital now.' Encourage family to wait to reevaluate patient when patient is more awake and let tylenol take effect. Family verbalized understanding. Patient assessed aprox [sic] 1 1/2hr later, patient continues to be very letheragic, unable to recognize granddaughter unble [sic] to answer questions appropriately. Agreed to send patient to ER, via facility van, family to meet patient there, MD notified, Paperwork sent with patient, Reports given to ER nurse...Will follow up;" and,</p> <p>* 5/4/14 at (PN) - "Pt admitted to [local medical center] today 5/4/14 @ 1700 [5:00 PM] for UTI..."</p> <p>On 3/12/15 at 12:53 PM, the DON was interviewed about Resident #11. She said the resident had a UA done on 4/21/14 which came back positive for a UTI of Streptococcus agalactise, and was started on Levaquin for 7 days on 4/22/14. The DON was asked when the physician should have been notified of the resident's signs and symptoms of infection displayed on 5/4/14, she stated, "Right away when they found them," and the nurse who waited 1.5 hours no longer worked in the facility.</p> <p>On 3/13/15 at 9:40 AM, the Administrator and DON were informed of the delay in treatment</p>	F 315			

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F 315 F 323 SS=D	<p>Continued From page 48 concerns. No further information was provided.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure adequate supervision to prevent falls. This was true for 1 of 6 residents (#6) sampled for falls. The deficient practice had the potential to cause harm when Resident #6 fell and the facility failed to implement care plan interventions deemed necessary to prevent falls. Findings included:</p> <p>Resident #6 was admitted to the facility on 1/19/15 with multiple diagnoses which included rehabilitation, history of falls, contusion of multiple sites and debility.</p> <p>The most recent admission MDS assessment, dated 2/2/15, documented the resident was cognitively intact, needed extensive assistance of one person for bed mobility, transfers, locomotion off and on the unit, dressing, toilet use and bathing. Additionally, the resident had impairment in functional limitation in range of motion on both sides, needed pain management and was at risk for developing pressure ulcers.</p>	F 315 F 323	<p><u>F 323</u></p> <ol style="list-style-type: none"> 1. Patient #6 discharged from the facility. 2. All patients who fall have the potential to be affected. <p>A root cause analysis revealed appropriate planning, implementation, and communication were not conducted for post fall interventions and documentation.</p> <p>We believe that staffing education is the best prevention. All nursing staff are required to initiate/update the patient care plans to include interventions for patients at risk for falls. We will identify these patients by nurse to nurse report, DON review of all new admission fall risk assessments, and DON review of all new admission care plans.</p> <p>Nursing staff were educated on proper interventions, communication, and documentation post fall. Also on care plan updates for those</p>	

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F 323	Continued From page 49 Resident #3's care plan documented under the focus area of "Risk for Falls," initiated 1/20/15, documented an intervention to, "Check q 1 h [every 1 hour] to ensure safety." An Incident Report, dated 2/28/15 at 7:15 PM, documented Resident #6 fell, without injury, when she attempted to self transfer from her WC to her bed and then used her call light. The resident was educated to use her call light when needing assistance. Record review did not contain documentation the resident was being checked on an hourly basis. On 3/12/15 at 9:00 AM, the DON was asked about the fall care plan intervention to check the resident every hour to ensure safety. When asked to see documentation for the hourly checks, the DON stated, "There isn't any, and I would expect to see an hourly Flow Sheet." On 3/12/15 at 5:10 PM, the Administrator and DON were made aware of the concern with not providing supervision per the resident's care plan to prevent falls. On 3/13/15 at 8:10, the DON was made aware of the fall concern due to not following the care plan intervention. No further information was provided by the facility.	F 323	interventions. Education provided at staff meeting on 3/31/15. 3. This will be maintained by a. Staff education as to awareness of patients at high risks for falls and interventions on patients at risk for falls. b. Director of Nursing will review all new admission fall risk assessments and care plans for falls. Any patient placed on safety checks will be monitored accordingly and flow sheets completed. Flow sheets are to be turned in for review to the DON each day. c. Post fall: fall prevention items to be reviewed by IDT and therapy to conduct patient education regarding fall prevention. d. At IDT fall risks will be reviewed. 4. DON or designee will conduct a weekly audit on all newly admitted patients for fall risk assessments, proper care plan interventions, and proper monitoring of patients on safety checks each week for 8 weeks.		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327			

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F 327	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were adequately hydrated. This was true for 1 of 1 sampled residents (#12) reviewed for dehydration. This failure had the potential to cause physical harm from dehydration and increased the resident's risk for urinary tract infections. Findings included:</p> <p>Resident #12 was admitted to the facility on 6/4/14 and readmitted on 6/21/14 with multiple diagnoses which included rehabilitation, paraplegia, bladder cancer and acute cystitis.</p> <p>Record review included documentation the resident was hospitalized on 6/18/14 at a local hospital. The Emergency Provider Report, dated 6/18/14 at 1:03 PM, documented in the Diagnosis, Assessment & Plan the resident had a syncopal event with no recurrence or lightheadedness in the hospital; dehydration and intravascular volume depletion; and, urinary tract infection, growing 40,000 colonies of Enterococcus, and ID (identification of medication sensitivity) was pending.</p> <p>The hospital Discharge Summary, dated 6/21/14, documented the final diagnoses which included urinary tract infection with Enterococcus faecalis, Ampicillin sensitive, and dehydration intravascular volume depletion.</p> <p>APN, dated 6/11/14 at 2:02 PM, documented the resident weighed 135 pounds. Based on the resident's weight, the daily baseline fluids needed</p>	F 327	<p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p> <p>F 327</p> <ol style="list-style-type: none"> 1. Patient #12 has discharged from the facility. 2. All patients have the potential to be affected. <p>A root cause analysis revealed appropriate documentation about education and encouragement of fluids being given to patients was lacking.</p> <p>We believe that staffing education is the best prevention. Nursing staff are required to document all fluid intakes with meals and additional fluid intakes not consumed with meals. If staff are aware of what they are looking for then this will</p>	

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F 327	<p>Continued From page 51</p> <p>were 1,830 cc per day. Record review of the resident's total fluid intake for the previous week the resident was hospitalized documented the following:</p> <ul style="list-style-type: none"> *6/11/14 - 840 cc *6/12/14 - 1,180 cc *6/13/14 - 1,590 cc *6/14/14 - 815 cc *6/15/14 - 780 cc *6/16/14 - 920 cc *6/17/14 - 700 cc <p>Record review of the following Progress Notes (PN) documented the resident was having fluid loss due to diarrhea or loose stools and laxatives were held on 6/13, 6/14, 6/15, and 6/16. However, no documentation was found in the PNs for encouraging fluids or that education was given regarding fluid loss and dehydration until 6/17/14.</p> <p>On 6/21/14 at 6:07 PM, a PN documented the resident was readmitted from a local hospital and was encouraged to drink fluids.</p> <p>No documentation was found in the resident's medical record a care plan for dehydration had been created, even after the resident returned from the local hospital with a diagnoses of urinary tract infection and dehydration.</p> <p>On 3/12/15 at 3:50 PM, the DON stated the facility had started weekly nutrition meetings to identify weight loss and fluid needs, however, those meetings were not being held at the time the resident resided in the facility. When asked if the facility was monitoring the resident's fluid intake, the DON stated, "I can't be sure on that."</p>	F 327	<p>facilitate prevention and/or management of dehydration. We will identify these patients by DON review of all new admission assessments, diagnoses, and orders; nurse to nurse report; and registered dietician evaluation of all new patients.</p> <p>DON educated nursing staff and therapist on documentation about education and encouragement of fluids being given to patients. This also included identifying patients who are experiencing diarrhea, loose stools, and those with laxative use. Education provided at staff meeting on 3/31/15.</p> <p>3. We will maintain this by</p> <ol style="list-style-type: none"> a. Nursing education with emphasis on prevention with awareness. Fluid intake to be charted on in Point of Care. b. Nursing staff will encourage fluid intake to all patients every shift, unless the patient has a fluid restriction c. Hydration Cart to promote fluid intake between meals 	

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F 327	Continued From page 52 On 3/12/15 at 5:10 PM, the Administrator and DON were made aware of the concern with hydration. No further information was provided by the facility.	F 327	d. Interdisciplinary team including the DON, RD and others as needed will meet weekly to review and implement any new interventions as needed on patients identified to be at increased risk for dehydration	
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; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure oxygenation saturations were monitored per physician orders, and care plans contained oxygen liter flow information. This was true for 4 of 6 sampled residents (#s 1, 2, 4 & 7) reviewed for specialty care. This created the potential to cause respiratory problems related to incorrect administration of oxygen, and a drop in oxygen saturation levels causing them to become anxious, confused or experience respiratory distress. Findings included: 1. Resident #2 was admitted to the facility on 2/13/15 with multiple diagnoses which included aftercare following a knee joint replacement and	F 328	e. Fluids offered at meal increased – Milk increased from 4oz to 8oz with two main meals; if a patient prefers no milk with meals, juice will be increased from 4oz to 8oz f. RD to alert DON after assessments if patient has decreased fluid intake. RD will educate patients at risk for dehydration. 4. DON or designee will conduct a random weekly audit on 3 patient's, for 8 weeks, for documentation of fluid intake and fluid encouragement. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested.	

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F 328	<p>Continued From page 53 obstructive sleep apnea.</p> <p>The most recent admission MDS assessment, dated 2/20/15, documented Resident #2 was cognitively intact with a BIMS of 15, and received oxygen therapy while a resident.</p> <p>Resident #2's Care Plan, initiated on 2/13/15, documented a focus of oxygen therapy related to ineffective gas exchange, and interventions which included, " O2 [oxygen] via nasal prongs/mask @ (1-2)L [liters] PRN [as needed]."</p> <p>The Order Summary Report for Resident #2 included an order, dated 2/13/15, which documented, "Oxygen at 1-4L per nasal cannula PRN. Check SATS [saturations] and monitor liter flow rate Q [every] shift. two times a day."</p> <p>Resident #2's Care Plan and Physician Orders contained conflicting information related to the oxygen liter flow.</p> <p>The March 2015 MAR documented the aforementioned Physician's Order for 1-4 liters of oxygen. Resident #2 had not received oxygen and the saturations remained at 90 % or above.</p> <p>On 3/10/15 at 3:06 PM, the DON was interviewed about oxygen for Resident #2. She said the care plan documented the resident had oxygen at settings of 1-2 liters PRN. When asked what the order for oxygen was, the DON said, "[It] says 1-4 liters."</p> <p>2. Resident #4 was admitted to the facility on 2/9/15 with multiple diagnoses which included a hip replacement and chronic airway obstruction.</p>	F 328	<p>5. Date of Completion 4/16/15</p> <p>F 328</p> <p>1. Patient #2 and 4 have discharged from the facility.</p> <p>Patient #1's care plan and orders for oxygen were corrected to match for liter flow and monitoring.</p> <p>Patient #7's care plan and orders for oxygen were corrected to match for liter flow and monitoring.</p> <p>2. All residents on oxygen have the potential to be affected.</p> <p>A root cause analysis revealed nurses checking of orders and care plans of patient's oxygen liter flow and saturation monitoring to be matching was lacking.</p> <p>We believe the staffing education is the best prevention. All nursing staff are required to initiate and update care plans to include oxygen settings when oxygen therapy is</p>	
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F 328	<p>Continued From page 54</p> <p>The most recent admission MDS assessment, dated 2/16/15, documented Resident #4 was cognitively intact with a BIMS of 15, and received oxygen therapy while a resident.</p> <p>Resident #4's Care Plan, initiated on 2/9/15, documented a focus of oxygen therapy PRN related to COPD (chronic obstructive pulmonary disease), and interventions which included oxygen therapy related to COPD.</p> <p>Note: On 3/10/15, when the surveyor requested copies of Resident #4's care plan for oxygen therapy, the interventions did not include the oxygen liter flow, nor did it document if the oxygen was PRN or continuous. However, once the surveyors received copies of the care plan, a revision was done, dated 3/10/15, which documented, "Oxygen at 1-4L per nasal cannula PRN. Check SATS and monitor liter flor rate Q shift." The orignal care plan was requested on 3/13/15 and on 3/16/15 at 12:27 PM by the DON, but was not provided.</p> <p>The Order Summary Report for Resident #4 included an order, dated 2/9/15, which documented, "Oxygen at 1-4L per nasal cannula PRN. Check SATS [saturations] and monitor liter flow rate Q [every] shift. two times a day."</p> <p>On 3/10/15 at 3:05 PM, the DON was asked what information should be on the care plan when a resident was receiving oxygen. She said the care plan should include settings for oxygen, what the physician ordered and the reason for oxygen, whether it was via mask or cannula, and the need of extension tubing. When asked what was missing from Resident #4's care plan, the DON said, "Her settings."</p>	F 328	<p>prescribed or changed. All nursing staff are required to monitor oxygen saturations and liter flow rate on all patients with oxygen therapy. We will identify these patients by nurse to nurse report, DON review for all new admission orders, care plans, and assessments.</p> <p>DON educated nursing on checking orders and care plans for patient's oxygen liter flow and saturation monitoring to match. Also on documenting the monitoring of theses properly. Education provided at staff meeting on 3/31/15.</p> <p>3. The DON educated nursing on checking orders and care plans for patient's oxygen liter flow and saturation monitoring to match. Also on documenting the monitoring of these properly. Education provided at staff meeting on 3/31/15</p> <p>4. This will be maintained by a. Nursing staff education to review patient orders upon admission and review of new orders with emphasis on those for oxygen therapy. All patients</p>	

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F 385 SS=D	<p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician's responded with treatment orders when communication was received regarding signs and symptoms of urinary tract infections. This was true for 1 of 2 random residents (# 11). This deficient practice had the potential to cause harm when a resident had blood tinged urine, the physician was notified but did not respond with treatment orders, and the resident was transported to the hospital with admitting diagnoses of urinary obstruction and sepsis. Findings included:</p> <p>Please see F 309 as it pertains to delay in treatment for this resident.</p> <p>Resident #11 was admitted to the facility on 4/14/14 with multiple diagnoses which included urinary obstruction and retention of urine.</p> <p>The Care Plan for Resident #11, dated 4/16/14, documented the resident had a suprapubic</p>	F 385	<p>that are identified as having oxygen therapy ordered are to be care planned for oxygen therapy including settings and monitored for oxygen saturations and liter flow rate.</p> <p>b. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented to maintain our systemic changes.</p> <p>DON or designee will conduct audits on all new admissions with prescribed oxygen therapy for 8 weeks, for orders and care plans of patients' oxygen liter flow matching. Also for saturation and liter flow monitoring.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p> <p><u>F 385</u></p>		

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F 385	<p>Continued From page 56</p> <p>catheter related to obstructive uropathy. The interventions included monitoring for signs and symptoms of discomfort on urinary frequency, monitoring and documenting pain or discomfort due to the catheter, and monitoring/recording/reporting to physician signs and symptoms of a UTI such as pain and blood tinged urine.</p> <p>The following information was gathered for Resident #11 from Physician's Orders (PO), Progress Notes (PN), Fax Sheet (FS),</p> <p>* 4/21/14 (PN) - "...Patient to see [Physician's name] this am. New orders for Levaquin 500mg po daily. Administered apon [sic] arival [sic]. New orders for UA [Urinary analysis] collection, sent to lab, waiting for results. Patient to see [Urologist's name] this afternoon...cath site cleansed with NS gauze surrounding cath[ether]. Draining dark colored urine...;"</p> <p>* 4/21/14 (PN) - "Supra-pubic cath care Q shift and PRN. Pt would not comply to recieve [sic] cath care. Will pass information on to next nurse to see if he will comply with the next nurse;"</p> <p>* 4/22/14 (PN) - "...New orders for Levaquin 500mg po daily...cath site cleansed with NS gauze surrounding cath. Draining dark amber colored urine...;"</p> <p>* 4/22/14 (PO) - "Urology Note: post op [operative] TURP [Transurethral Resection of the Prostate] [and] s-pubic [supra-pubic] cystotomy - Have asked nurses to clamp S-P tube and have him void - they will then open the S-P tube to measure residual urine volume;"</p> <p>* 4/23/14 (PN) - "Phoned [Urologist's name] office about pt. Pt is still incontinent. Tried to clamp off urianry [sic] tubing and pt would urinate in his pants. Pt has no clue when he needs to go. Waiting for new orders;"</p>	F 385	<ol style="list-style-type: none"> 1. Patient #11 has discharged from the facility. 2. All patients have the potential to be affected. <p>A root cause analysis revealed nurses were not continuing to follow up with physicians after notification of a change of condition to them has occurred for a response and any new orders that may be needed.</p> <p>We believe that staffing education is the best prevention. All nursing staff are required to perform a complete assessment of their patients and notify the physician of any significant changes, including following up on notifications until a response is given. All nursing staff are required to document physician response. We will identify these patients by utilization of the Interact Tool on Change in Condition: "When to notify the MD" and Care Paths, the nurse to nurse report, and review of nursing progress notes.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2015
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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F 385	<p>Continued From page 57</p> <p>* 4/23/14 (PO) - "Check bladder residual twice a shift. Document ML residual and on 4-25-14 fax results to [Urologist's name];"</p> <p>* 4/25/14 (PN) - "...Pt has had blood tinged urine this evening, faxed information to [Physician's name], waiting for further orders. Bladder residual taken throughout shift, information faxed to [Physician's name], waiting for further orders...;"</p> <p>* 4/25/14 (FS) - "Pt has blood tinged uring 4/25/14. Please inform of any new orders. Pt's urine residual today 4/25/14 was @ 0800 [8:00 AM] - 0 mL, @ 1200 [12:00 PM] - 1.5 mL[,] @ 1600 [4:00 PM] - 2 mL;"</p> <p>* 4/27/14 (PN) - "...Suprapubic catheter in place, draining amber colored urine. Patient encouraged [sic] to drink fluids and requires frequent reminders to drink. Fresh ice water provided and placed with in reach. Continues on levaquin daily for UTI. Patient denies suprapubic pain upon palpation...;"</p> <p>* 4/27/14 (PN) - "Urine residual information sent via fax to [Urologist's name] 4/27/14. Waiting for further orders;"</p> <p>* 5/3/14 (PN) - "...Pts suprapub cath care done today and gauze dressing changed. Pt stated pain during change. Pt coughing today, cough is productive. Pt advised to sit up in bed to help with cough...;"</p> <p>* 5/3/14 (PN) - "Levaquin order recieved [sic] today 5/3/14 from [Physician's name]...due to pts cough. Order placed in physicians orders;"</p> <p>* 5/4/14 (PN) - "Patient is drowsy [sic], disoriented to time, place, situation. Patient has expiratory wheezing...Heart rate iregular [sic]. While administering medications observed patient was clammy, red, and lethargic. Patient vitals WNL, temp was 101.7, patient window opened, jacket taken off, applied cold wash cloth to forehead. Patients granddaughter in room with</p>	F 385	<p>DON educated nursing on following up on notifications of physicians for their response and any new treatment orders to the change of condition. This includes involving administration when a physician is not responding, to help in getting a physician response.</p> <p>3. We will maintain this by</p> <p>a. Nursing education on assessment and notification of physician on change in condition, utilization of Interact Tools, and following up with physician until a response is given.</p> <p>b. If after one hour of no response from physician, nursing will contact Administrator or DON for further effort to contact physician. If the need is urgent or if nursing and the administrator or DON are unable to contact the physician, the patient will be sent to the ER.</p> <p>c. Through our continued monitoring these processes will be evaluated and any additional processes will be implemented</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 385	Continued From page 58 patient. Reports 'This is how he was before he went to the hospital, I think he needs to go to the hospital now.' Encourage family to wait to reevaluate patient when patient is more awake and let tylenol take effect. Family verbalized understanding. Patient assessed aprox [sic] 1 1/2hr later, patient continues to be very lethargic, unable to recognize granddaughter unble [sic] to answer questions appropriately. Agreed to send patient to ER, via facility van, family to meet patient there, MD notified, Paperwork sent with patient, Reports given to ER nurse...Will follow up;" and, * 5/4/14 (PN) - "Pt admitted to [local medical center] today 5/4/14 @ 1700 [5:00 PM] for UTI..." On 3/12/15 at 12:53 PM, the DON was interviewed about Resident #11. When asked about the physician's response to the fax regarding blood tinged urine, the DON said she was, "Not seeing anything." When asked about the physician's response to the urine residual information, the DON stated, "Judging from this [the computer system] there wasn't any" orders or physician response. She said there was nothing indicating there was follow-up with the physician. On 3/13/15 at 9:40 AM, the Administrator and DON were informed of the concerns with the lack of physician response to blood tinged urine and the lack of follow-up. No further information was provided.	F 385	to maintain our systemic changes. 4. DON or designee will conduct 3 random weekly audits on patients for documentation of physician notification and any new orders, for 8 weeks. Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN. A nurse consultant will assist with reviews as requested. 5. Date of Completion 4/16/15 <u>F 518</u> 1. All core staff were educated on the Power Outage and Missing Resident Policy and Procedures. 2. All staff and residents have the potential to be affected. A root cause analysis revealed staff were lacking in education on the policy and procedures	
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518		

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F 518	<p>Continued From page 59 staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Policy & Procedure review and staff interview, it was determined the facility failed to ensure staff were trained on procedures for missing residents and a power outage. This was true for 3 of 3 staff members (CNA #1 & 2 and LN #3) interviewed on emergency procedures. This deficient practice had the potential for harm should an emergency arise and staff not know how to respond. Findings included:</p> <p>The facility's Policy and Procedure for a Missing Resident, revised 12/2007, documented: "1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. 4. Interventions to try to maintain safety will be included in the resident's care plan. 5. Nursing staff will document circumstances related to unsafe actions, including wandering, by a resident. 6. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. 7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing</p>	F 518	<p>for missing patients and power outages.</p> <p>We believe staffing education is the best prevention. All core staff are required to review and know the location of the disaster policies and procedures. We will identify these staff members by review of the disaster policies and procedures upon hire and mandatory staff meetings.</p> <p>The Administrator and Maintenance Director educated staff on the policy and procedures for missing patients and power outages. Also on the location of all disaster policy and procedures. Education provided at staff meeting on 3/31/15.</p> <p>3. We will maintain this by a. Staff education on policies and procedures for power outage and missing residents, including where to find these and other disaster policies. All core staff attended the staff meeting on 3/31/15 where education was provided.</p>	

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F 518	<p>Continued From page 60 from the unit or facility."</p> <p>a. On 3/10/15 at 11:10 AM, CNA #1 was asked what to do if a resident went missing, and she said she did not know what to do, but would find out. At 11:20 AM, the CNA reported back to the surveyor the policy for a missing resident. The CNA said she asked the Administrator for the information.</p> <p>b. On 3/10/15 at 2:25 PM, CNA #2 was asked what to do if the power went out, and she would find out. When asked which outlets were powered by the generator, the CNA said she was unsure. At 2:42 PM, the CNA reported back to the surveyor and said when the generator came on the red outlets worked.</p> <p>c. On 3/11/15 at 10:30 AM, LN #3 was asked what to do if a resident went missing, and she said she was not sure and would get back to the surveyor. At 10:43 AM, the LN said if the resident was not in the building she would call the DON and Administrator and follow their instructions.</p> <p>On 3/12/15 at 11:30 AM, the Administrator was interviewed regarding employee preparedness for a power outage and missing resident. He acknowledged he received multiple questions from staff and needed to change up the education to include possible role play to help them remember the protocols.</p> <p>On 3/12/15 at 5:05 PM, the Administrator and DON were informed of the concerns related to staff knowledge about disaster protocols. No further information was provided.</p>	F 518	<p>b. Review of the disaster binder added to the new hire checklist, to be completed with each new employee.</p> <p>c. Disaster policies and procedures will be reviewed at every mandatory staff meeting.</p> <p>4. Administrator or designee will conduct a random weekly audit on 4 staff members for 4 weeks about the procedure for missing patients and power outage procedure and where to find the information to follow the policy and procedure for disasters.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>A nurse consultant will assist with reviews as requested.</p> <p>5. Date of Completion 4/16/15</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2015
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NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406
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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 surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, and Lauren Hoard, RN, BSN	C 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Promontory Point Rehabilitation does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies". C 664 02.150,02,a	
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 the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from each department was included and signed in at the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings included: The Infection Control Protocol was reviewed on 3/11/15 at 9:00 AM with the Infection Control Coordinator who provided the sign in sheet from the Quarterly Infection Control Meetings. Upon review of the sign-in sheets, it was determined following departments were not represented: *Dietary, Housekeeping and Maintenance for the February 2015 meeting; *Pharmacist for the June 2014 meeting; and, *Pharmacist for the April 2014 meeting. On 3/11/14 at 9:45 AM the Infection Control Coordinator/DON stated she would make sure there was a representative from each department at each upcoming Quarterly Infection Control	C 664		

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	 <small>6899</small>	TITLE Administrator	(X6) DATE 4/23/15
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2015
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C 664	<p>Continued From page 1</p> <p>Meeting. She stated the facility had changed pharmacists as they had problems with their attendance.</p> <p>On 3/11/15 at 4:50 PM, the Administrator and DON were made aware of the above concern. No further information was provided by the facility.</p>	C 664	<p>which was affecting attendance of meetings at the facility.</p> <p>3. The facilities DON educated the representatives from the departments who are required members of the quarterly infection control meetings that their attendance is required. The facility also changed pharmacists due to the problems with attendance for facility meetings.</p> <p>4. DON or designee will conduct a quarterly audit on 2 quarterly infection control meetings for those required departments to have representation and signing of the sign-in sheets.</p> <p>Areas of concern will be addressed immediately and discussed at QA (Quality Assurance) meeting, monthly and PRN.</p> <p>5. Date of Completion 4/16/15</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 21, 2015

Teresa Bruun, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Ms. Bruun:

On **March 13, 2015**, an unannounced on-site complaint survey was conducted at Promontory Point Rehabilitation.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from March 9 to March 13, 2015.

The following observations were completed:

Residents were observed for pressure ulcer prevention measures.

The following documents were reviewed:

An identified resident's medical record was reviewed;
Other residents' records were reviewed;
The facility's Grievance file was reviewed;
Resident Council minutes were reviewed;
The facility's Incident and Accident reports were reviewed; and,
The facility's Allegation of Abuse reports were reviewed.

The following interviews were completed:

Several residents were interviewed regarding Quality of Care concerns;

Teresa Bruun, Administrator
August 21, 2015
Page 2 of 3

The resident group was interviewed for Quality of Care concerns; and,
The Director of Nursing was interviewed regarding various Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006460

ALLEGATION #1:

The complainant stated an identified resident developed pressure sores due to improper evaluation and treatment.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the record review and staff interview the facility was cited at F314. Please refer to Federal Report 2567.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility failed to identify an upper respiratory infection for an identified resident and provide timely treatment for the infection.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the record review and staff interview the facility was cited at F157 and F309. Please refer to Federal Report 2567.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

Teresa Bruun, Administrator

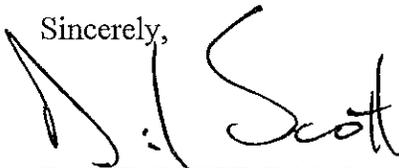
August 21, 2015

Page 3 of 3

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

DS/lj



IDAHO DEPARTMENT OF
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E-mail: fsb@dhw.idaho.gov

FILE COPY

August 21, 2015

Teresa Bruun, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Ms. Bruun:

On **March 13, 2015**, an unannounced on-site complaint survey was conducted at Promontory Point Rehabilitation.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from March 9 to March 13, 2015.

The complaint allegations, findings and conclusions are as follows:

The following observations were completed:

Residents were observed for catheter care.

The following documents were reviewed:

An identified resident's medical record was reviewed;
Other residents' records were reviewed;
The facility's Grievance file was reviewed;
Resident Council minutes were reviewed;
The facility's Incident and Accident reports were reviewed; and,
The facility's Allegation of Abuse reports were reviewed.

Teresa Bruun, Administrator
August 21, 2015
Page 2 of 3

The following interviews were completed:

Several residents were interviewed regarding Quality of Care concerns;
The resident group was interviewed for Quality of Care concerns; and,
The Director of Nursing was interviewed regarding various Quality of Care concerns.

Complaint #ID00006480

ALLEGATION #1:

The complainant stated an identified resident did not receive appropriate catheter care and suffered a delay of treatment, when the resident acquired a urinary tract infection (UTI) which required hospitalization.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the record review and staff interview, the facility was cited at F309 and F315. Please refer to Federal Report 2567.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident received a delay in treatment prior to a hospitalization for a urinary tract infection (UTI.)

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the record review and staff interview the facility was cited at F385. Please refer to Federal Report 2567.

Teresa Bruun, Administrator
August 21, 2015
Page 3 of 3

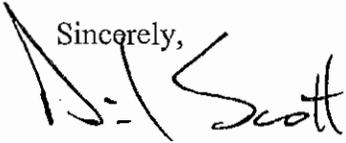
CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

DS/lj



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PH COPY

August 21, 2015

Teresa Bruun, Administrator
Promontory Point Rehabilitation
3909 South 25th East
Ammon, ID 83406

Provider #: 135137

Dear Ms. Bruun:

On **March 13, 2015**, an unannounced on-site complaint survey was conducted at Promontory Point Rehabilitation.

The following observations were completed:

Residents were observed for hydration and oxygen needs.

The following documents were reviewed:

An identified resident's medical record was reviewed;
Other resident's records were reviewed;
The facility's Grievance file was reviewed;
Resident Council minutes were reviewed;
The facility's Incident and Accident reports were reviewed; and,
The facility's Allegation of Abuse reports were reviewed.

The following interviews were completed:

Several residents were interviewed regarding Quality of Care concerns;
The resident group was interviewed for Quality of Care concerns; and,

The Director of Nursing was interviewed regarding various Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006653

ALLEGATION #1:

The complainant stated an identified resident did not receive appropriate catheter care and did not receive adequate hydration, which resulted in a urinary tract infection and hospitalization.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the record review and staff interview the facility was cited at F157, F309, F315, and F327. Please refer to Federal Report 2567.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated a resident did not receive appropriate oxygen treatment for a continuous positive airway pressure or bi-level positive airway pressure (CPAP or BIPAP) machine.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from March 9 to March 13, 2015.

FINDINGS:

Residents with oxygen, CPAP, and BIPAP machines were reviewed for proper placement and no concerns were identified.

Resident interviews and residents in the group interview did not express concerns for oxygen, CPAP or BIPAP usage.

Based on observations, record review, and resident interview, it was determined the allegation could not be substantiated.

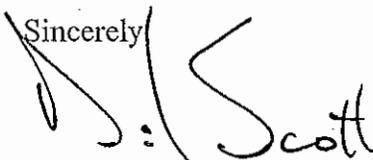
Teresa Bruun, Administrator
August 21, 2015
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CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,


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

DS/lj