



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

APR 15 2015
April 15, 2015

Ralph K. Allen, Jr., Interim Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Allen:

On **March 30, 2015**, a survey was conducted at Good Samaritan Society - Idaho Falls Village 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 in your facility to be **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **March 26, 2015**.

On **March 27, 2015**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form 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. If applicable, a similar State Form will be provided 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**

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provide **ONLY ONE** completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 28, 2015**. Failure to submit an acceptable PoC by **April 28, 2015**, may result in the imposition of additional civil monetary penalties by **May 18, 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Based on the immediate jeopardy cited during this survey:

F309 -- S/S: K -- 42 CFR §483.25 -- Provide Care/Services for Highest Well Being

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This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

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

A 'per instance' civil money penalty of \$10,000.00

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 30, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F309 -- S/S: K -- 42 CFR §483.25 -- Provide Care/Services for Highest Well Being

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1, 2, 3, 4, 5, 14, 17** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, Option 2; fax

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number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 28, 2015**. If your request for informal dispute resolution is received after **April 28, 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: 04/15/2015
FORM APPROVED
OMB NO. 0938-0391

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|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/30/2015 |
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|--|--|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Becky Thomas, RN Kendra Deines, BSN</p> <p>The survey team entered the facility on March 23, 2015 and exited on March 30, 2015</p> <p>Survey Definitions: ADL = Activities of Daily Living BG = Blood Glucose BIMS = Brief Interview for Mental Status BID = Two times per day cm = Centimeters CNA = Certified Nurse Aide CRE = Carbapenem Resistant Enterobacteriaceae DA = Dietary Aide DDS = Director of Dietary Services DON = Director of Nursing ESBL = Extended Spectrum Beta-Lactamses HS = Hour of sleep LN = Licensed Nurse e-MAR/MAR = electronic Medication Administration Record/Medication Administration Record MDS = Minimum Data Set assessment ML = Milliliter MRSA = Methicillin Resistant Staphylococcus Aureus PRN = As Needed QID = Four times per day</p> | F 000 | <p><u>General Disclaimer</u></p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> | |
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MDS UNIT 1015

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|---|----------------------------------|-------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Walter K. Collier</i> | TITLE Executive Administrator | (X6) DATE 03/01/2015 |
|---|----------------------------------|-------------------------|

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

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| F 000 | Continued From page 1 | F 000 | | | |
| F 166 SS=E | <p>VRE = Vancomycin Resistant Enterococci WC = Wheelchair</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, Resident Group Interview, review of the facility's Suggestion or Concern file, and staff interview, it was determined the facility did not ensure residents were informed of how or where to file a grievance. This was true to 6 of 11 residents in the Group Interview. This created the potential for psychosocial harm if resident concerns were not addressed. Findings included:</p> <p>On 3/24/15 at 1:00 PM, during the Resident Group Interview, the residents were asked if they knew how to file a grievance or complaint, 6 of 11 residents said they were not aware of how to file a grievance. The residents who knew how to file a grievance were asked if there was a location in the facility to find the grievance forms, they said they were not aware of a location, but they would go to the social work office to report grievances.</p> <p>On 3/24/15 at 4:10 PM, a location where Suggestion or Concern forms were kept could not be found in the facility.</p> <p>On 3/26/15, the facility's February 2013</p> | F 166 | <ol style="list-style-type: none"> 1. A grievance form was completed for resident #7 on 3/30/2015. Suggestion/concern/grievance box and a file with suggestion/concern forms were placed outside social services office. 2. All residents have the potential to be affected by this practice. 3. Residents and families receive a suggestion/concern form on admission. Residents were educated by Ombudsman at resident council meeting 4/21/2015 on how to report a grievance, and where the suggestion/concern/grievance box is located. The center will check the suggestion/concern box daily to identify any resident, family or staff concerns. All residents were given a page with pictures of Administrator, DNS, and LSW to assist them with reporting. This page will also be provided in the | | |

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| F 166 | <p>Continued From page 2</p> <p>Grievances, Complaints or Concerns procedure was requested and reviewed. The procedure documented:</p> <p>"10. The social services department will be responsible for posting this procedure in an area accessible to residents/families and visitors. This responsibility also includes educating staff, residents, family and visitors on the use of this form, as well as where visitors, staff and residents can obtain forms for filing or how to verbalize their suggestion/concerns."</p> <p>On 3/26/15 at 11:35 AM, the Social Worker was interviewed about grievances. When asked how residents or families would know how to file a grievance, she said upon admission they are given the process and a form. When asked if there was a public area where the Suggestion or Concern forms were found, she said there was not, but they could obtain one in the social work office or at the nurse's stations. She also said staff would be able to help residents file a grievance. She also confirmed there had only been two official grievances for the facility since July 15, 2014.</p> <p>On 3/26/15 at 11:52 AM, LN #2 was interviewed about grievances. When asked if she knew about filing a grievance on behalf of a resident, she stated, "I'm not aware of any formal process." She was also unaware where to find Complaint or Concerns forms for residents, visitors or staff to complete.</p> <p>On 3/27/15 at 5:30 PM, the Administrator, DON and Social Worker was informed of the issues. No further information was provided by the facility.</p> | F 166 | <p>admission packet for all new admissions beginning 4/20/2015.</p> <p>Nursing staff were educated regarding the grievance policy/procedure by LSW and Administrator on 4/9/2015. All staff were re-educated on 4/23/2015 on process change and procedure for reporting grievances.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit change to process weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015</p> | 5/30/15 | |

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| F 241 F 241 SS=D | Continued From page 3 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure residents were treated with respect and dignity. This was true for 3 random residents (#s 13, 19, & 21) when a blood glucose (BG) was checked while a resident sat on the toilet and when staff entered residents' rooms without waiting for a response or permission. The deficient practices created the potential for a negative psychological effect if the residents experienced a lack of respect for their privacy. Findings include: 1. On 3/23/15 at 11:30 a.m., 2 surveyors observed as LN #2 entered Resident #13's room to administer medications and perform a BG check. However, the resident said he needed to use the restroom first. LN#2 assisted the resident to the restroom, then asked the resident, "Is it okay if I check your blood sugar while you use the bathroom?" The resident stated, "Yes." The LN then took the BG equipment into the restroom and checked the resident's blood glucose while he sat on the toilet. (Refer to F 441, Infection Control, for details about the BG equipment in the restroom.) 2. On 3/26/15 at 4:00 p.m., LN #3 was observed during medication pass for resident #21. The LN | F 241 F 241 | 1. Resident #13's glucose will be checked in an appropriate location to protect resident's dignity. Resident #19 Staff bringing meal tray will knock and wait for a response prior to entering. Resident #21 Staff will await response or permission prior to entering resident room. 2. All Residents have the potential to be affected by these practices. 3. Blood glucose will now be checked in areas that provide dignity and privacy. Resident privacy will be respected by staff knocking and awaiting response or permission prior to entering resident rooms. All staff were educated on dignity and respect pertaining to knocking on resident rooms and waiting for a response or permission to enter on 4/23/15. | | |

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| F 241 | Continued From page 4 knocked on the resident's door but did not wait for the resident's response or permission before entering. On 3/26/15 at 6:10 p.m., the Administrator, DON, and Director of Social Services were notified of the issue. The facility did not provide any additional information on the issue. 3. On 3/25/15 at 1:10 PM, CNA #17 was observed to pass hall lunch trays to residents who ate in their rooms. CNA #17 entered Resident #19's room with her lunch tray and then knocked on the door. On 3/25/15 at 1:15 PM, CNA #17 stated, "I was trying to get things done. I should have knocked before entering." On 3/26/15 at 6:10 PM, the Administrator and DON were made aware of the dignity concerns. No further information was provided. | F 241 | Licensed nurse in-service on blood glucose monitoring including safeguarding resident dignity completed on 4/9/15. 4. Monitoring will be through direct observation of staff and resident interactions. Results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit weekly X 4, monthly X 2, and quarterly X 3. 5. Compliance on or before May 30, 2015. | 5/30/15 | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was | F 246 | | | |

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| F 246 | <p>Continued From page 5</p> <p>determined the facility failed to ensure residents call lights were within reach for 3 sampled residents (#s 3, 5 & 6). The deficient practice had the potential to cause harm if the resident's needs were not met. Findings included:</p> <p>1. On 3/23/15 at 4:25 PM, the call light cord in Resident #5's bathroom was observed to be wrapped around the grab bar and the call light would not turn on when pulled from below the grab bar.</p> <p>On 3/23/15 at 4:30 PM, LN #4 was shown the cord and she said the cord should not have been wrapped around the grab bar. She unwrapped the cord and said the resident may have placed it in that position and staff would have to watch that.</p> <p>2. On 3/23/15 at 4:15 PM, Resident #6 was observed lying on the bed in her room. The call light cord was partially under her pillow, but the call button was not visible. When asked if she could use her call light, she looked for it and said she could not find it, but she could go into the bathroom and use the call light there.</p> <p>On 3/23/15 at 4:17 PM, LN #13 was asked if he could find the residents call light button. After searching for it, he found it and said it was, "partially under her pillow, but mostly on the floor." He acknowledged the button portion of the call light was found on the floor next to her bed.</p> <p>3. Resident #3 was admitted to the facility in 2013 and readmitted 12/1/14, 5/16/14, and 2/7/15 with multiple diagnoses including contracture of lower leg joint, generalized pain, and unspecified hemiplegia affecting non-dominant side.</p> <p>The resident's most recent quarterly MDS</p> | F 246 | <ol style="list-style-type: none"> 1. Resident #3, 5, and 6 call lights were immediately placed within reach and Resident #3's bulb style call light was replaced and care plan updated on 3/25/15 with a touch pad call light. 2. All residents have the potential to be affected by this practice. 3. Residents will be assessed to determine placement and type of call light to ensure it is within reach and able to be used. <p>Nursing staff in-serviced 4/9/15 to ensure call lights are always readily accessible and able to be used. All staff in-serviced on 4/23/15 to ensure call lights are within residents' reach.</p> <ol style="list-style-type: none"> 4. Monitoring will be through resident observation, demonstration, and chart review. Results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Social services or designee will audit weekly X 4, monthly X 2, and quarterly X 3. | |

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| F 246 | <p>Continued From page 6</p> <p>assessment, dated 1/25/15, coding included intact cognition with a BIMS score of 15, and extensive or total assistance needed for bed mobility/transfers/dressing/toileting/hygiene, functional limitation in both lower extremities, frequent urinary and bowel incontinence, occasional pain at an 8 out 10 (10 being the worst pain), and wheelchair use.</p> <p>On 3/25/15 at 4:45 p.m., Resident #3 was observed in bed. When asked if how she summoned help if she needed it or wanted something, the resident said she would use the call light. When asked to activate the call light, the resident looked and felt around her clothing and the bed linens for the call light for several minutes without success. When informed the call light was clipped to the top side of the pillow under her head, the resident stated, "I can't reach it there. That's not where it's supposed to be." The resident said she frequently had difficulty squeezing the bulb call light to get it to work. With the resident's permission, the surveyor activated the call light.</p> <p>At 4:50 p.m., the DON and 2 other staff entered the resident's room. When asked about the position of the call light, the DON acknowledged that the resident could not reach it. A staff member moved the call light to within the resident's reach and the surveyor asked the resident to squeeze the bulb call light. The resident was unable to squeeze the bulb enough to activate the call light and she told the DON she could not always squeeze it enough to get it to work. The DON said the resident's call light would be changed to a touch pad call light right away.</p> <p>On 3/26/15 at 6:10 PM, the Administrator, DON</p> | F 246 | 5. Compliance on or before May 30, 2015. | 5/30/15 | |

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| F 246 | Continued From page 7 | F 246 | | | |
| F 252 SS=E | <p>and Social Worker were informed of the issues. No further information was provided by the facility.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure a clean, comfortable, and homelike environment for 10 of 10 sample residents (#s 1-10) and any resident who moved about the Hall 100 CNA Station or drank from 3 of 4 drinking fountains (Halls 100 and 300), and all residents in the vicinity of Resident #4's and random Resident #23's room. The deficient practice created the potential for psychosocial harm when residents were exposed to ripped and missing wallpaper at the CNA Station, mineral deposits on water fountain spouts, and urine odors. Findings included:</p> <p>1. During the survey week, from 3/23/15 to 3/27/15, the wallpaper on the half wall at the Hall 100 CNA Station was noted to be missing or torn in 2 places, each approximately 5 inches long by 4 inches wide, and horizontal scrapes were all the way across the 10 foot wall.</p> <p>On 3/27/15 at 9:30 am, during a tour of the</p> | F 252 | <p>1. Resident #23 was moved into a different room on 4/21/15. Urologist consult request 4/17/15.</p> <p>Resident #4 was moved into a different room on 4/20/15. Assessment and resident education regarding incontinence, proper fitting incontinence product use, and care plan intervention to offer increased assistance added 4/17/15. Urologist consult requested, and new medication order received 4/17/15.</p> <p>Resident's 1-10: Drinking fountains cleaned on 3/26/15. Torn wallpaper was removed and wall repainted on 4/1/15.</p> <p>2. All residents have the potential to be affected by these practices.</p> <p>3. Rooms and drinking fountains were placed on a routine cleaning schedule with deep clean as needed.</p> | | |

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| F 252 | <p>Continued From page 8</p> <p>environment with the Director of Environmental Services (DES), the DES was asked about the CNA Station wallpaper. He acknowledged the wallpaper was in disrepair and said, "It needs to be replaced."</p> <p>2. On 3/23/15 and 3/24/15, a crusty green discoloration was noted around and/or immediately below the drinking spout on the 2 water fountains on Hall 100 and the water fountain on Hall 300.</p> <p>On 3/24/15 at 12:55 pm, the Housekeeping Supervisor (HS) was asked about the green discoloration on the aforementioned water fountains. The HS stated, "I try to clean them once in awhile. They could use a cleaning." The HS added, "It's a mineral build up."</p> <p>3. On 3/23/15 at 1:30 pm, a urine odor was detected in Resident #23's restroom.</p> <p>On 3/24/15 at 9:15 am, the urine odor was detected in the doorway to the resident's room and at 3:00 pm in the hallway by the resident's room.</p> <p>On 3/25/15 at 8:10 am, the urine odor was again noted in the doorway to the resident's room and by 9:10 am, the urine odor was noticeable in the hallway outside the resident's room.</p> <p>On 3/26/15 in the morning and the afternoon, the urine odor varied from noticeable only at the doorway to noticeable in the hallway near the resident's room.</p> <p>On 3/27/15 at 9:25 am, during a tour of the environment with the DES, the DES said "Yes"</p> | F 252 | <p>Residents with changes in continence that promote odor will be re-assessed and room care provided to reduce or prevent odor and provide a clean and comfortable homelike environment.</p> <p>In-service completed for housekeeping staff regarding mineral deposit removal on 4/24/15.</p> <p>In-service completed for maintenance staff to address addition to the TELS program on 4/24/15.</p> <p>Nursing staff re-educated on odor prevention and reporting odor concerns to maintenance on 4/30/14.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Staff development coordinator or designee will audit weekly X 4, monthly X 2, and quarterly X 3.</p> | | |

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| F 252 | Continued From page 9 when asked if he noticed a urine smell at Resident #23's room. The DES stated, "It's not the carpet and it wasn't the mattress the last time we looked at it." The DES said the last time he "looked at" the urine odor issue was January 2015. 4. From 3/23/15 to 3/25/15, the following observations were made of Resident #4's room: 3/23/15 -4:22 PM, The resident was not in her room. There was a strong urine odor found in the room and just outside the room in the hallway; 3/24/15 -9:20 AM, The resident was in her room and there was a strong urine odor; At 4:05 PM, The resident was not in her room and there was a strong urine odor found in the room; and, 3/25/15 -12:55 PM, the resident was not in her room and there was a strong urine odor found in the room. On 3/27/15 at 9:55 AM, the Maintenance Supervisor was asked about the urine smell in Resident #4's room. He said the last room she was in had the same issue and believed the smell "followed" the resident. On 3/27/15 at 5:30 PM, the Administrator, DON and Social Worker were informed of the issues. No further information was provided by the facility. | F 252 | 5. Compliance on or before May 30, 2015. | 5/30/15 | |
| 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 comprehensive plan of care. | F 279 | | | |

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| F 279 | <p>Continued From page 10</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 observation, interview and record review, the facility failed to develop interim care plans which reflected the current status for 2 of 11 sample residents (#5 and #11). Failure to address Resident #11's intrathecal baclofen pump created the potential for delay in care and treatment should the pump malfunction; and, inclusion of a Wanderguard for elopement in Resident #5' care plan, without supporting evidence, created the potential for psychosocial harm if the resident felt he could not walk freely throughout the facility. Findings included:</p> <p>1. Review of Resident #11's closed record revealed he was admitted to the facility on 12/12/14 with a diagnosis of spasticity; and, discharged on 12/23/14.</p> <p>The resident's History and Physical (H & P),</p> | F 279 | <ol style="list-style-type: none"> 1. Resident #11 discharged 12/23/14. Resident #5 was reassessed for elopement risk and wander guard was discontinued, care plan updated on 4/2/15. 2. Residents with intrathecal baclofen pump(s) or with a risk for elopement have the potential to be affected by this practice. 3. Residents with intrathecal baclofen pumps will have initial care plan to address care/treatment/monitoring needs and what to do if pump malfunctions. <p>Residents at risk for elopement will be assessed for supporting evidence prior to use of a wander guard and assessed for the potential of psychological harm.</p> <p>Licensed nurses in-service on baclofen pump initial care plan and what to do should the pump malfunction by 4/30/15. Licensed nursing staff and social services in-service on requirement for supporting evidence</p> | | |

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| F 279 | <p>Continued From page 11</p> <p>dated 12/8/14, included the following documentation, "History of Present Illness: ...seen...2008...for...placement of a baclofen pump...pump was now at the near end of life and he is back for a replacement of pump. We interrogated the pump. There is 2000 mcg [micrograms] per mL [milliLiter] of baclofen, he is on 1500 and 6.2 mcg per day...He has a 20 mL pump in...Plan: Replacement..."</p> <p>The resident's TCU/SNF (Transitional Care Unit/Skilled Nursing Facility) Admission Orders, dated 12/12/14, included, "Dressing/Wound Instructions: keep dry - staples out @ [at] my office 12/19/14." The baclofen pump was not mentioned in these orders.</p> <p>The resident's Progress Notes (PNs), dated 12/12-12/23/14, included 4 entries about a right abdominal incision. The baclofen pump, however, was noted only twice, on 12/21 and 12/22 as "Status post replacement of Baclofen pump." There were no other entries about the baclofen pump.</p> <p>The resident's care plan, printed 3/27/15, included the focus area, "...acute/chronic pain/discomfort R/T [related to] spasticity, recent surgery to replace baclofen pump." Interventions were, "Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s [signs/symptoms] or c/o [complaint of] pain or discomfort. Provide...reassurance that pain is time limited... Observe/record/report to Nurse and s/s of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless,</p> | F 279 | <p>documentation prior to placement of wander guard 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Staff development coordinator or designee will audit care plans for current and comprehensive information weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 279 | <p>Continued From page 12</p> <p>aggressive, squirmy, constant motion); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying, worried, scared, clenched teeth, grimacing) body (tense, rigid, rocking, curled up, thrashing)." The Medical Records Supervisor said the print date, 3/27/15, was assigned when the resident's closed record was reopened on that date.</p> <p>The resident's care plan did not include the dosage of the baclofen or that the medication was infused continuously. The care plan did not document where the implanted pump was located. The care plan did not contain any information regarding the signs and symptoms of Baclofen overdose, or other problems that could occur with the use of an intrathecal pump including infection, kinking, coiling or breaking of the catheter. The care plan did not include any information on the Baclofen pump alarm system and what interventions were necessary if the alarms sounded.</p> <p>On 3/27/15 at 3:40 p.m., the DON was asked about the lack of care planning regarding the resident's intrathecal baclofen pump. The DON reviewed the care plan then confirmed that the baclofen pump was not care planned.</p> <p>The facility did not provide any other information about the issue.</p> <p>2. The facility's revised Elopement Procedure dated September 2013, documented: "2. At the time of admission, identify all residents who are at risk for elopement on the care plan with interventions specific to the resident to minimize individual risk.</p> | F 279 | | | |

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| F 279 | <p>Continued From page 13</p> <p>4. Care plan team members should consider the following when assessing risk of elopement:</p> <ul style="list-style-type: none"> a. Wandering behavior..; b. History of elopement; c. Cognitive impairment; d. Attempts to leave center; e. Residents who are new admits to the center; and, f. Recent alteration in resident's mental status..." <p>Resident #5 was admitted to the facility on 3/18/15 with multiple diagnoses including paralysis agitans, dementia without behavioral disturbances, psychosis, schizoaffective disorder, and anxiety.</p> <p>The resident's physician progress note and history and physical, dated 2/19/15, did not document the resident was at risk for elopement.</p> <p>The resident's admission orders, dated 3/12/15, did not document the resident was at risk for elopement.</p> <p>The resident's Nursing Admit Re-admit Data Collection form, dated 3/18/15, documented under the ADL section, "Able to ambulate without assistive device but requires extra time due to shuffle gait..." The form did not document the resident was at risk for elopement.</p> <p>The resident's initial care plan, dated 3/18/15, documented a focus of, "[Resident #5] is ...Unaware of safety needs." With an intervention of, "Personal Alarm: Wanderguard [elopement device] used to alert staff to resident's movement and to assist staff in monitoring movement."</p> <p>The resident's progress notes, dated 3/18/15 at</p> | F 279 | | | |

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| F 279 | <p>Continued From page 14</p> <p>1:23 PM and 9:36 PM, documented, "resident cooperative with cares this shift. Stays in room until meal times. Able to find dining room on his own but needs guidance back to bedroom after supper..." and "Wanderguard for elopement risk placed on right wrist."</p> <p>The resident's progress notes, dated 3/25/15 at 10:01 PM, documented, "Placed Wanderguard on R[ight] ankle."</p> <p>The following observations were made from 3/23/15 to 3/25/14:</p> <p>3/23/15 -4:25 PM, The resident was in the recliner in his room, watching TV;</p> <p>3/24/15 -8:30 AM, The resident was in the recliner in his room, watching TV;</p> <p>-8:43 AM, The resident's call light was on and a staff member went into his room and a minute later, they walked down to the Rehabilitation Dining Room together;</p> <p>-9:15 AM, The resident walked, by himself, from the dining room to his room;</p> <p>-10:40 AM, The resident was in the recliner in his room, sleeping;</p> <p>-12:40 PM, The resident was in the dining room eating independently;</p> <p>-3:12 PM, The resident was in the recliner in his room watching TV, turned his call light on and requested a piece of candy from the CNA who answered his light;</p> <p>3/25/15 -9:35 AM, The resident was in the recliner in his room, watching TV;</p> <p>-12:50 PM, The resident was in his recliner in his room, eating his lunch; and,</p> <p>5:40 PM, The resident was in his recliner in his room, eating his dinner. A Wanderguard was attached to his right ankle.</p> <p>On 3/26/15 at 9:30 AM, the DON stated, "The</p> | F 279 | | | |

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| F 279 | Continued From page 15 care plan says he's an elopement risk." The DON was unable to find documentation in the resident's record where he was an elopement risk, nor clarify why the Wanderguard was placed. | F 279 | | | |
| F 280 SS=E | On 3/27/15 at 5:30 PM, the Administrator, DON and Social Worker were informed of the issues. No further information was provided by the facility. 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 observation, record review and staff interview, it was determined the facility failed to | F 280 | 1. Resident #1's care plan updated for fall risk to include use of anti-reverse brakes on 3/27/15 and care plan for pain control updated to include non-pharmacological interventions on 4/23/15. Wanderguard re-assessed and discontinued on 4/3/15. Resident exhibited elopement attempt, was re-evaluated, wander guard was reinitiated and care plan updated on 4/16/15. Resident #2 Care plan updated per resident preference for urinal placement on 4/15/15. 2. Residents with elopement risk, falls, pain, and resident preferences for urinal placement have the potential to be affected by these practices. | | |

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| F 280 | <p>Continued From page 16</p> <p>review and revise care plans for 2 of 9 sampled residents (#s 1 & 2). Resident #1's care plan had not been updated or revised to include the resident was no longer an elopement risk, failed to include a fall intervention added after the resident fell and did not include non-pharmacological interventions for pain control. Resident #2's care plan failed to include a resident preference for urinal placement in his room. This had the potential for harm should residents receive inappropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>The annual and quarterly MDS assessments, dated 10/10/14 and 1/8/15, documented the resident was severely cognitively impaired with a BIMS score of 3, did not exhibit behaviors, reject care or have wandering behaviors.</p> <p>a. A review of the Incident Reports for Resident #1, documented the resident was found on the floor next to her bed, on 2/21/15 at 12:50 PM, without any injuries. It was determined the wheelchair brakes had not been locked and the resident had probably attempted to self-transfer. The report documented a predisposing factor was the resident's impaired memory.</p> <p>A Physical Device and Restraint Assessment, dated 2/26/15 at 10:54 AM, documented antireverse brakes were recommended for the resident's wheelchair.</p> <p>Review of Resident #1's care plan for the focus of falls, initiated 10/29/13 and revised 1/20/14, did</p> | F 280 | <p>3. Licensed nursing staff will review; update and/or revise care plans to ensure they include interventions in relation to resident's current status and stated preferences.</p> <p>Licensed nurses in-serviced on changes to this process completed on 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit care plans weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/30/2015 |
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| F 280 | <p>Continued From page 17</p> <p>not include an intervention for antireverse brakes to the resident's wheelchair.</p> <p>On 3/27/15 at 3:35 PM, LN #8 was asked about the antireverse brakes care plan intervention. She stated the antireverse brakes were needed because the resident did not remember to lock the wheelchair brakes. When asked if the care plan had been revised with the new intervention, LN #8 stated, "No, it should have been."</p> <p>b. The resident's Medication Review Report for March 2015, documented an order, dated 7/28/14, "Check Wanderguard every shift for elopement risk related to Dementia."</p> <p>The Treatment Record for March 2015, documented the facility was checking the Wanderguard on the day and evening shifts.</p> <p>Review of Resident #1's care plan for the focus of potential for elopement, initiated 12/7/13 and revised on 1/6/14, documented the resident wore a Wanderguard and to check it every shift.</p> <p>On 3/27/15 at 3:35 PM, LN #8 stated if they notice residents wander or approach exits then they will get an order for a Wanderguard. When shown the latest annual and quarterly MDS assessments, LN #8 stated, "It should be removed but we should continue to monitor for any wandering behavior." When asked if the facility had non-pharmacological interventions for the focus of pain, LN #8 stated, "Nothing is care planned."</p> <p>c. Review of Resident #1's care plan for the problem of pain documented two care plans had been developed. The first care plan focused on</p> | F 280 | | |

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| F 280 | <p>Continued From page 18</p> <p>the problem of chronic pain/discomfort, which was initiated 10/29/13 and revised 2/20/15, documented one intervention, to rate the resident's pain using the facial expression interpretation or PAINAD scale. The second care plan focused on the problem of pain medication therapy. Neither of the care plans for pain included non-pharmacological interventions.</p> <p>On 3/27/15 at 3:35 PM, LN #8 was asked if the care plan for pain should be revised to included non-pharmacological interventions, LN #8 stated, "Yes."</p> <p>On 3/27/15 at 5:30 PM, the Administrator and DON were made aware of the Wanderguard concern and multiple care plan concerns. No further information was provided by the facility.</p> <p>On 3/23/15 at 4:30 p.m., Resident #2's urinal was observed on the bedside table, along with some of his other belongings and water cup. A metal urinal holder was observed attached to the bed frame.</p> <p>On 3/24/15 at 8:30 a.m., CNA #15 was interviewed, with Resident #2 present. CNA #15 was unable to identify what the urinal holder was, and referred to the resident for an answer. The resident stated, "They say the urinal and water aren't supposed to be on the same shelf, so we are supposed to use that, but I like it [the urinal] there [on the bedside table]."</p> <p>The resident's care plan did not reflect the resident's preference for the urinal to be kept on the bedside table, instead of the urinal holder. Progress notes, however, addressed education about infection control regarding this issue.</p> | F 280 | | | |

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| F 280 | Continued From page 19 | F 280 | | |
| F 309 SS=K | <p>3/27/15 at 5:30 p.m., the Administrator, DON, Director of Social Services, and Case Manager was notified of the issue. No further information was provided for this issue.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of the facility's hypoglycemia procedure, it was determined the health and safety of 5 of 5 sample residents (#s 1, 2, 3, 4, and 5), two random residents (#s 14 and 17), nine other residents with a diagnosis of diabetes, and any resident who could experience hypo- and/or hyperglycemia (low or high blood glucose levels) were in Immediate Jeopardy and at risk for serious harm, impairment, or death when the facility: a) failed to ensure physician's orders for hypoglycemia (blood glucose below 70) met accepted standards of professional practice for Resident #1 and #2. Their orders instructed Glucagon injection or Glucose gel/paste for a blood glucose (BG) less than 80, and Resident #1's orders instructed BG checks twice a day with</p> | F 309 | <ol style="list-style-type: none"> Resident # 1, 2, 3, 4, 5, 14, and 17 diabetic management regimens reviewed and revised per abatement plan of correction on 3/27/15. Resident #5's orthostatic blood pressure was reviewed and physician notified of results and refusals 4/29/15. Residents with diabetes who could experience hypo or hyperglycemia and any resident with need for orthostatic blood pressure monitoring have the potential to be affected by this practice. Upon admit of a resident with diabetes nursing will contact the physician if appropriate for sliding scale insulin as well as individualized parameters for hyperglycemia and | |

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| F 309 | <p>Continued From page 20</p> <p>sliding scale (SS) insulin as needed, which the facility did at 8 am and 9 pm during their normal morning and bedtime medication (med) pass times, rather than fasting before breakfast and dinner as the physician intended;</p> <p>b) failed to consistently implement interventions and recheck BG levels multiple times when Resident #2 experienced hypoglycemia;</p> <p>c) failed to notify the physician when Resident #2's insulin was repeatedly held, refused or the dosage was changed;</p> <p>d) failed to ensure Resident #s 1-5's physician's orders included parameters for hypoglycemia and hyperglycemia (BG above 110);</p> <p>e) failed to check the BG and administer insulin at the correct time for Resident #14;</p> <p>f) failed to ensure a hyperglycemia procedure/guideline was in place for Resident #s 1-5 and all other diabetic residents and any resident who could experience hyperglycemia;</p> <p>g) failed to notify the physician when Resident # 2, #3 and #5 experienced hyperglycemia; and,</p> <p>h) failed to ensure an insulin pharmacy label matched Resident #17's physician's orders.</p> <p>Additionally, Resident #5's blood pressure was not consistently measured as ordered to monitor for hypertension. The failure created the potential that undetected hypertension may not be treated, if indicated.</p> <p>The American Diabetes Association's (ADA) article, Hypoglycemia (Low Blood Glucose), last edited 9/16/14, defined hypoglycemia as, "...a condition characterized by abnormally low blood glucose (blood sugar) levels, usually less than 70 mg/dl [milligrams/deciliter]...may also be referred to as an insulin reaction, or insulin shock...The only sure way to know whether you are</p> | F 309 | <p>hypoglycemia. Within PCC orders nurse will replace the AC/ HS administration times with the actual start times of meals. Nursing will check BG and administer insulin in a private location just prior to the resident eating their meal. Nursing staff will ensure diabetic residents receive their meals within 30 minutes of insulin administration.</p> <p>All nurses in-serviced on Hypoglycemic Incidents Procedure and to obtain doctors order to use said Procedures unless otherwise specified by the physician during that call. Nursing instructed to follow Hyperglycemia parameters per orders, and to identify if symptoms are present to contact resident's physician. Nursing in-serviced to clarify with physicians at what blood glucose level they want to be notified of hyperglycemic incidents for resident's on an anti-diabetic medication. Nurses will notify if a resident is symptomatic.</p> | |
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| F 309 | <p>Continued From page 21</p> <p>experiencing hypoglycemia is to check your blood glucose...Severe hypoglycemia has the potential to cause accidents, injuries, coma, and death...left untreated, hypoglycemia may lead to a seizure or unconsciousness... Glucagon is a hormone that stimulates your liver to release stored glucose into your bloodstream when...blood glucose levels are too low... Hypoglycemia unawareness occurs more frequently in those who: * frequently have low blood glucose episodes (...can cause you to stop sensing the early warning signs of hypoglycemia) * have had diabetes for a long time * tightly control their diabetes (...increases...chances of having low blood glucose reactions)... Other Causes of Symptoms[:] Other people may start to have symptoms...when their blood glucose levels are higher than 70 mg/dl. This can happen when...blood glucose levels are very high and start to go down quickly. If this is happening, discuss treatment with...health care provider."</p> <p>The ADA's article, Hyperglycemia (High Blood Glucose), last edited 9/16/14, defined hyperglycemia as, "...technical term for high blood glucose (blood sugar)...happens when the body has too little insulin or when the body can't use insulin properly... Checking your blood and then treating high blood glucose early will help...avoid problems associated with hyperglycemia...Hyperglycemia can be a serious problem...fail to treat hyperglycemia, a condition called ketoacidosis...could occur...Ketoacidosis is life-threatening and needs immediate treatment..."</p> <p>The ADA's article, Checking Your Blood Glucose, last edited 3/3/15, documented the following regarding blood glucose target ranges, "Blood</p> | F 309 | <p>Nurses in-service completed 3/28/15 on diabetic management procedure changes, documenting interventions, physician notification, response, and follow up by rechecking blood sugar within 15 minutes of administration of the intervention.</p> <p>License nurse in-service 4/30/15 to address documentation of care/refusal of care in regards to orthostatic blood pressure monitoring.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Health information manager or designee will audit diabetes management and orthostatic blood pressure monitoring weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 309 | <p>Continued From page 22</p> <p>glucose targets are individualized based on: * duration of diabetes * age/life expectancy * comorbid conditions * known CVD [cardiovascular disease] or advanced microvascular complications * hypoglycemia unawareness * individual patient considerations. The American Diabetes Association suggests the following targets for most nonpregnant adults with diabetes. More or less stringent glycemic goals may be appropriate for each individual. * A1C [laboratory test to measure glucose control over the previous 2-3 months]: 7% * A1C may also be reported as eAG: 154 mg/dl * Before a meal (preprandial plasma glucose); 70-130 mg/dl * 1-2 hours after beginning of the meal (Postprandial plasma glucose): less than 180 mg/dl..."</p> <p>On 3/26/15 at 3:50 p.m., the Administrator and DNS were informed verbally and in writing of the Immediate Jeopardy (IJ) situation. They were provided examples of residents who had not received proper and timely care and treatment for hypo- and hyperglycemia and the overall lack of appropriate diabetic management.</p> <p>On 3/27/15 at 6:45 p.m., the facility provided the survey team with an acceptable abatement plan and the IJ was abated.</p> <p>The abatement plan included a procedure for insulin to be administered within a certain time limit before a meal service, a review of the orders for all diabetic residents with clarification of the orders to include the Hypoglycemia Incident Procedure, physician contact for hypo- and hyperglycemia parameters, a change within PCC (Point Click Care, the facility's electronic medical record computer program) from AC/HS (before meals and bedtime) to the start time of meals so</p> | F 309 | | | |

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| F 309 | <p>Continued From page 23</p> <p>that residents receive their meal within 30 minutes of insulin administration, and training of all nurses on duty regarding the aforementioned changes as well as timely interventions, recheck BGs after interventions, and physician notification with other nurses to be educated before starting their shift.</p> <p>Findings included:</p> <p>Note: On 3/25/15 at 3:00 p.m., the survey team requested the facility's policies and procedures regarding hypo- and hyperglycemia. On 3/26/15, a Hypoglycemic Incidents Procedure, dated September 2012, was provided.</p> <p>The facility's Hypoglycemic Incidents Procedure documented, "1. On admission or when a resident is newly diagnosed with diabetes, an individual physician's order should be obtained for treatment of hypoglycemia and parameters for when treatment should be initiated. 2. For blood glucose levels 70 and below, or physician's guidelines, as long as resident is able to swallow...: a. Give a rapidly absorbed carbohydrate* such as 1) 4 oz [ounces] of orange, apple or grape juice OR 2) 6 oz of regular soda *These amounts are equal to 15 grams of carbohydrate. b. Repeat blood glucose test after 15 minutes. c. Repeat administration of carbohydrate if necessary. d. Follow with longer-acting carbohydrate protein such as: 1) Cheese and crackers 2) Milk and fruit 3) Sandwich e. Notify physician. f. Monitor blood glucose levels every 15 minutes until blood glucose level is above 70. 3. For blood glucose levels 45 or below as long as resident is able to swallow: a. Give glucopaste / glucogel / tube per physician's order. (15 gm. is standard; however</p> | F 309 | | |

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| F 309 | <p>Continued From page 24</p> <p>need to check physician's order) b. Repeat blood glucose test after 15 minutes. c. If continues 45 or below, repeat glucopaste or glucogel after 15 minutes...if resident remains alert to swallow. d. Notify physician immediately...on-call for attending physician or the medical director; if not available contact the emergency room for further direction. 4. If...unable to swallow and has an order for glucagon IM (intramuscular) or SL (sublingual), it should be administered, or the resident...transported to local emergency room... a. Glucagon should be given per physician's order and physician notified per policy. b. Monitor blood glucose levels every 15 to 30 minutes until blood glucose level is above 70. 5..."</p> <p>1. Resident # 2 was admitted to the facility on 2/10/14 and readmitted 8/4/14 with multiple diagnoses including Diabetes Mellitus (DM).</p> <p>Note: On 8/28/14 at 12:30 pm, Resident #2 experienced a life threatening episode of hypoglycemia when his BG measured 30. He was documented as being lethargic, pale, and confused after a fall from his wheelchair. Juice was given, rather than Glucopaste/gel per the facility's Hypoglycemic Incident Procedure. However, the resident's BG was not rechecked after the juice was given. Then, at 12:44 pm, a glucagon 1 mg SC injection was administered. Fifteen minutes later his BG was 63. However, no other interventions or BG rechecks were documented. In addition, there was no documented evidence the physician was notified of the hypoglycemic event or that glucagon SC was administered. In addition, on 3/7/15 at 9:34 pm, an LN attempted to administer glucagon 1 mg per SC injection when the resident's BG was</p> | F 309 | | | |

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| F 309 | <p>Continued From page 25</p> <p>63. However, the resident refused the injection. The glucagon injection could have raised the resident's BG so much that Humalog insulin would have been necessary.</p> <p>Note: The facility's Hypoglycemic Incident Procedure instructed glucagon by injection for a BG of 45 or lower if the resident was unable to swallow. There was no documented evidence the resident was unable to swallow when he refused the injection.</p> <p>Note: The survey team first noted diabetic management problems that occurred in August 2014; however, the problems persisted and were still evident during the March 2015 survey.</p> <p>Resident #2's significant change and two most recent quarterly MDS assessments, dated 8/11/14, 10/30/14 and 1/29/15 respectively, documented intact cognition with a BIMS score of 15 and that insulin was administered 7 of 7 days in the look back period.</p> <p>The resident's current Medication Review Report included the following orders/start dates related to diabetes:</p> <ul style="list-style-type: none"> * Lantus insulin 18 units by subcutaneous (SC) injection twice a day - 8/4/14; * Humalog insulin SC per sliding scale before meals and at bedtime: BG of 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-400 give 8 units, 401 + (plus) give 10 units, and above or equal to 401 give 10 units - 10/23/14; * BG check PRN (as needed) for signs/symptoms of hypoglycemia - 10/28/14; * Glucagon emergency kit 1 milligram inject 1 dose SC PRN "low blood sugar" - 7/24/14; and, | F 309 | | | |

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| F 309 | <p>Continued From page 26</p> <p>* Glucose Gel 40 % give 1 dose by mouth PRN hypoglycemia - 10/28/14.</p> <p>The resident's care plan for DM included the following interventions and dates: * "Monitor/document/report to health care provider PRN s/s (signs/symptoms) of hypoglycemia: Sweating, tremor, increased heart rate...pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait." Initiated 5/27/14; * "Snack/food...midmorning daily." Initiated 8/29/14, revised 2/11/15; * "Monitor/document/report to health care provider PRN for s/s of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (difficult breathing and often preceding diabetic coma), acetone breath (smells fruity), stupor, coma." Initiated 2/20/14; and, * "Educate resident/family: Diabetes complications and preventions. [Resident's name] requests to be awakened when resting for BG checks and do not hold Lantus administration when BG is low." It was initiated and revised 5/27/14.</p> <p>The aforementioned orders and care plan did not include any parameters for hypoglycemia or hyperglycemia or when to notify the physician if the resident's BG was too low or too high. Additionally, neither the physician's orders nor the care plan included or referred to the Hypoglycemia Incidents Procedure.</p> <p>The resident's August 2014 MAR documented the resident's scheduled Lantus insulin was held 8 times and refused twice; and, that his BG was</p> | F 309 | | | |

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| F 309 | Continued From page 27 495 on 8/12 at 11:00 a.m. In addition, the August 2014 MAR documented the resident's BG levels were less than 70 on 8/7 at 7 am = 47, 8/10 at 7 am = 48, 8/17 at 9 pm = 56, 8/19 at 7 am = 41, 8/24 at 7 am = 45, 8/26 at 7 am = 44, and 8/27 at 7 am = 59 and at 4 pm = 62. Resident #2's August 2014 Progress Notes (PNs) included the following documentation: 8/7 at 7:53 am - "Blood sugar 47, resident ate candy bar and 240 ml [milliliters] of milk." * A recheck BG was not documented. 8/8 at 8:56 pm - "Lantus...Held per resident request, stated he'd had an 'insulin reaction' for past two mornings." * The 9:00 pm BG was documented as 202. 8/9 at 8:56 pm - "Lantus...Held per nursing judgement d/t [due to] low bs [blood sugar] in am and BS at 91." * The BG of 91 was within the accepted normal range. In addition, there was no documentation of any signs and symptoms (s/s) of hypoglycemia or that the physician was notified that Lantus was held for a "low" BG. 8/10 at 9:03 pm - "Lantus...Held per nursing judgement d/t low blood sugars in am, was at 42 this morning." * An intervention and recheck BG was not documented when the BG was 42. 8/10 at 9:04 pm - "HumaLOG...Held d/t resident's request, resident concerned about drop in BS in am, and did not want to take HS [bedtime] snack to keep BS up at night." * The 9:00 pm BG was documented as 172. 8/14 at 8:51 pm - "Lantus...Held per resident request, stated he doesn't have lantus [sic] at night to prevent drop of BS in am." | F 309 | | | |

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| F 309 | <p>Continued From page 28</p> <p>* The BG scheduled for 9:00 pm was documented as 133. 8/15 at 9:06 pm - "Lantus...Held per nursing judgement and per resident request." * The 9:00 pm BG was documented as 149. 8/17 at 9:14 pm - "Lantus...held for a blood glucose of 56, Snack provided. Rechecked in 15 minutes. now 65 and climbing." * No other intervention or recheck BG was documented when the BG was 65. * 8/17 at 11:21 pm - "...received his meds [medications] and blood glucose checked, it is 56. Lantus has been withheld and pt [patient] given a snack of milk and a candybar per his request...15 minutes after snack. Blood glucose is rechecked and has come up to 65. Pt reports feeling fine. Will continue to monitor..." * No documented evidence of any further intervention or BG recheck. 8/18 at 5:33 am - "Blood Glucose is 47 this morning after holding his insulin last night [sic], given orange juice and a cheese stick, will recheck in about 15 minutes." * A recheck BG was not documented; however, the 7:00 am BG check (almost 1 1/2 hours later) documented the BG was 130. In addition, there was no documented evidence of any s/s of hypoglycemia or why his BG was checked at 5:33 a.m., almost 1 1/2 hours before the breakfast meal was scheduled to start at 7:00 a.m. 8/19 at 6:41 am - "[R]es. bs was 41 at 0605 [6:05 a.m.], night shift gave juice, cheese...rechecked at 0640 [6:40 a.m.] @ [at] 88." * The BG was rechecked 35 minutes, not 15 minutes, after the intervention. 8/19 at 8:52 pm - "Lantus...BS below 150, held per nursing judgement and d/t resident request [sic]." * The BG scheduled for 9:00 pm was</p> | F 309 | | | |

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| F 309 | <p>Continued From page 29</p> <p>documented as 136.</p> <p>8/23 at 9:15 pm - "HumaLOG...Resident refused d/t drop in BS previous am, BS was 257."</p> <p>* There was no documented evidence the physician was notified about the refusal.</p> <p>8/24 at 9:14 pm - "Lantus...Held d/t nursing judgement. When administered on 8/23, BS dropped to 43 in am."</p> <p>* The 7:00 am BG on 8/23 was documented as 45 in the August MAR. However, there was no documented evidence that any interventions or BG rechecks were done.</p> <p>8/25 at 10:09 pm - Late Entry "...blood glucose levels continue to be very low in the mornings. pt [sic] refusing Humalog for sliding scale at all and wants us to cut the amount of Lantus he takes. Have asked the doctor to review his blood sugars and adjust the doses accordingly, will continue to monitor..."</p> <p>* There was no documented evidence that the facility followed-up with the physician.</p> <p>8/28 at 12:30 pm - "...found on floor...doesn't remember falls or nurse in the room at 1100 [11:00 a.m.] to check blood sugar...blood sugar post fall was 30, gave resident juice and PRN Glucagon." And, "...told he should consume a snack in the morning after therapy due to insulin working better in the tissue after exercise...Verbalized understanding...Will be reinforced by therapy."</p> <p>* The 11:00 am BG (an hour before the scheduled meal service) was documented as 73. However, by 12:30 p.m., the BG was 30. Nothing was documented about the resident's level of consciousness when the BG was 30. However, the first intervention documented was juice, which indicated the resident was conscious and able to swallow. There was no documentation about why juice, rather than Glucose Gel 40% was not</p> | F 309 | | |

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| F 309 | <p>Continued From page 30</p> <p>administered as ordered for hypoglycemia if the resident was able to swallow. Additionally, the facility's Hypoglycemic Incident Procedure which instructed Glucopaste or Gel for a BG of 45 or below if the resident was able to swallow, was not followed.</p> <p>8/28 at 12:44 pm - "Glucagon Emergency Kit 1 MG Inject 1 dose subcutaneously as needed for low blood sugar. Residents blood sugar was 30, resident is lethargic, pale, and confused, will continue to monitor."</p> <p>* There was documentation that the resident was unable to swallow at this time.</p> <p>8/28 at 1:00 pm - "...blood sugar is 63."</p> <p>* No other intervention or recheck BG was documented.</p> <p>8/28 at 8:17 pm - "HumaLOG...pt refused based on severe drops in his blood glucose levels. Would also only take 6 units of the lantus [sic]."</p> <p>* No documentation that the physician was notified about the refusal and dosage change.</p> <p>8/29 at 10:31 am - "Care Plan change made to ensure resident gets a snack midmorning after therapy to ensure blood sugar does not drop too low."</p> <p>8/30 9:22 pm - "Lantus...refused d/t low BG of 98."</p> <p>8/31 9:36 pm - "HumaLOG...Resident refused d/t recent a.m. hypoglycemia episodes."</p> <p>There was no documented evidence that interventions were consistently implemented when the resident was hypoglycemic or that his BG was rechecked 15 minutes after an intervention was implemented for hypoglycemia. Also, there was no documented evidence the physician was notified of the frequent episodes of hypoglycemia, that Lantus and Humalog insulin were held or refused repeatedly from 8/7/14 to</p> | F 309 | | | |

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| F 309 | <p>Continued From page 31</p> <p>8/25/14 (18 days) and from 8/28 to 8/31 (4 days), that different doses of the insulin medications were administered per the resident request, or when the BG was over 400. In addition, there was no documented evidence the facility followed-up with the physician after notification about hypoglycemia on 8/25/14 or informed the physician of severe hypoglycemia 3 days later, on 8/28/14, when the resident's BG dropped to 30.</p> <p>The resident's MAR for 3/1/15 - 3/24/15 documented the resident's BG was greater than 400 as follows: 3/7 at 11:00 am = 449, 3/11 at 7:00 am = 438, 3/13 at 11:00 am = 484, 3/14 at 7 am = 405, 3/19 at 4:00 pm = 416, and 3/22 at 4:00 pm = 416. However, there was no documented evidence the physician was notified when the resident's BG was over 400 in March 2015.</p> <p>The March 2015 MAR and/or PNs also contained documentation that the resident refused the HS dose of Lantus insulin 21 times, 3/1, 3/3-3/6, 3/8-3/10, 3/12-3/14, and 3/18-3/27; requested a different dose of Lantus on 3/11 at 9:45 pm, and "7 units" rather than the ordered 18 units was administered; and, the resident refused the Humalog insulin per the s/s when his HS (9:00 pm) BG measured 140 to 516 on 3/1-3/6, 3/8, 3/10-3/14, 3/16, 3/23, and 3/27. However, there was no documented evidence the physician was notified when the insulin medications were refused or when a different dose than ordered was administered.</p> <p>The March 2015 MAR also contained documentation that the resident's BG levels were less than 70 on 3/6 at 7 am = 63, 3/7 at 9 pm = 63; and 3/15 at 9 pm = 57. The MAR included the</p> | F 309 | | | |

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| F 309 | <p>Continued From page 32</p> <p>orders for Glucagon SC and Glucose Gel 40 % by mouth as needed for hypoglycemia. However, the only documented intervention for hypoglycemia was on 3/7 at 9:34 pm when the resident refused an attempted Glucagon 1 mg SC injection.</p> <p>The March 2015 PNs also documented the following: 3/6 - There were no entries when the resident's BG was documented as 63 at 7:00 am. on the MAR, which indicated that no interventions were implemented and the BG was not rechecked. 3/7 at 10:16 pm - "...blood glucose was low at 2100 [9:00 pm] was 63 pt was given juice, crackers and cheese and banna [sic] at 2300 [11:00 pm] was 198..." * The March 2015 MAR documented that the resident refused a Glucagon SC injection at 8:35 pm when the BG scheduled for 9:00 pm was 63. In addition, the BG recheck was done 2 hours, not 15 minutes, after the intervention with food for hypoglycemia. 3/12 at 11:55 pm - "...BG at HS: 516...would only allow 6 U [units] of Humalog..." * Again, there was no documented evidence the physician was notified about the extremely high BG or that a different dose of Humalog was administered. 3/15 at 10:15 pm - "...Lethargic, generalized weakness. C/O [complaint of] 'I can't think straight'...Reports he hasn't been feeling well and that he did not eat well for supper. Hands are shaking. Blood sugar low at 57. Tx [treatment] for his low blood sugar provided. Resident able to eat w/ [with] assistance. Requires being fed. Will f/u [follow up] on blood sugar in 30 min[utes]..." * What the "Tx" was was not documented and a BG recheck was not documented.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 33</p> <p>On 3/26/15 at 2:20 pm, the DON was interviewed and asked about orders for Glucagon SC or Glucopaste/gel for residents with a BG less than 80. The DON said, "The nurse should follow the hypoglycemia policy."</p> <p>On 3/26/15 at 3:35 pm, the DON was asked if the facility had a policy or protocol for hyperglycemia. She said the facility did not have a hyperglycemia policy and that the nurses would, "Use standard practice if [BG] over 400, call MD [Medical Doctor]."</p> <p>On 3/27/15 at 12:15 pm, the Medical Director (MD) was interviewed by telephone about diabetic management in the facility. When asked about the Hypoglycemic Incident Procedure, the MD said he was familiar with the procedure and had approved it, but he was not involved in creating it. When asked about orders for Glucagon SC or Glucopaste/gel for BG levels less than 80, the MD said "70 to 110" was the normal BG range and the intent was that staff would monitor a resident whose BG was under 80 and recheck the BG as needed. He said staff should "use their best judgement" and that "80 would be an area they look at as a potential issue going on." Regarding residents without specific orders for interventions for hypoglycemia, the MD stated, "If the facility has a protocol then follow it and then if there are questions talk to the doctor." Regarding orders for BG checks and SS insulin twice a day, the MD stated, "I would do a fasting blood sugar before breakfast and then before dinner."</p> <p>Resident #2 was in immediate jeopardy when the facility failed to provide adequate diabetic</p> | F 309 | | |

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| F 309 | <p>Continued From page 34</p> <p>management as evidenced by the facility's attempt to administer a Glucagon SC injection when the resident's BG was 63 and the resident was able to refuse the injection; the facility did not follow the physician ordered intervention for Glucose Gel, or the Hypoglycemic Incident Procedure, when his BG was 30 and juice, not Glucose Gel, was administered; the facility did not provide consistent or appropriate interventions or follow-up monitoring when the resident experienced numerous episodes of extremely low and extremely high BG levels; and, the facility failed to notify the physician when the resident's BG levels were less than 70 or over 400 and when the resident refused antidiabetic medications or requested different doses of the medications.</p> <p>2. Resident #3 was admitted to the facility on 2013, and readmitted 12/1/13, 5/16/14, and 2/7/15 with multiple diagnoses including diabetes mellitus.</p> <p>The resident's current Medication Review Report included an order for Novolog insulin per sliding scale and to call the physician if the resident's blood glucose (BG) was over 400.</p> <p>The March 2015 e-MAR contained documentation that the resident's BG was over 400 on 3/10 at 9:00 pm = 442, 3/11 at 4:00 pm = 445 and 9:00 pm = 412, 3/17 at 9:00 pm = 435, and 3/23 at 4:00 pm = 426.</p> <p>Review of the resident's electronic medical record revealed there was no documented evidence the resident's physician was notified when the BG was over 400.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 35</p> <p>On 3/26/15 at 6:10 pm, the Administrator, DON, and Director of Social Services were notified of the BG issue.</p> <p>On 3/27/15 at 1:00 pm, LN #8 was asked if the physician was notified when the resident's BG was over 400. The LN said she would do some research and get back with the surveyor.</p> <p>On 3/27/15 at 4:45 pm, LN #8 stated, "No, we did not find any documentation the nurses notified the physician [when the resident's BG was over 400]."</p> <p>The facility did not provide any further information about the issue.</p> <p>3. Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>Resident's #1 Annual MDS assessment, dated 10/10/14, and Quarterly MDS assessment, dated 1/8/15, documented the resident was severely cognitively impaired with a BIMS score of 3.</p> <p>The care plan for diabetes mellitus, initiated 10/29/13, documented the following interventions: *Observe for signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, muscle cramps, abdominal pain, rapid/deep breathing, fruity smelling breath, change in level of consciousness; and, *Observe for and report to nurse signs and symptoms of hypoglycemia: sweating, tremor increased heart rate, pale skin, nervousness, confusion slurred speech, lack of coordination and staggering gait.</p> | F 309 | | |

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| F 309 | <p>Continued From page 36</p> <p>NOTE: The care plan did not contain acceptable blood glucose parameters, hypoglycemia or hyperglycemia interventions or refer to the facility's policy and procedure.</p> <p>The 3/24/15 Medication Review Report (Recapitulation Orders) documented the following physician orders: *Humalog Solution Inject as per sliding scale: If 200-250 = 2 units; 251-300 = 4 units; 301 - 350 = 6 units; 351-400 = 8 units, subcutaneously two times a day for diabetes, with a start date of 9/30/13; *Glucagon Emergency Kit 1 MG Inject 1 gram intramuscularly as need for Blood Glucose < 80. Give if unable to swallow, with a start date of 9/30/13; *Glucose 15 Gel 40%, give 15 gram by mouth as needed for blood glucose < 80 and food contraindicated. Give 15 Gms PO (per oral). If unable to swallow give Glucagon, with a start date of 9/30/13; and, *Blood glucose check as needed for s/sx of hypoglycemia, with a start date of 10/28/14.</p> <p>The March 2015 MAR documented BG (Blood Glucose) levels were scheduled at 8 AM and 9 PM.</p> <p>NOTE: The orders directed staff to give Glucagon intramuscularly before giving a high carbohydrate snack. Blood glucose checks were ordered twice per day and lacked direction when BG levels should be drawn, e.g., fasting or before meals. There was no direction in the physician order what to do if the BG levels were above 400. Additionally, the facility did not have a hyperglycemia policy.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 37</p> <p>On 3/26/15 at 2:20 PM, the DON stated BG levels are scheduled per the doctor's order and, unless the physician ordered a specific time, it would default to the AM and HS med pass. When asked if a nurse should question a BG level done after the resident ate a meal, the DON stated it would depend on how stable the resident was, but, typically BG levels were fasting. When asked if a BG should be done at 9 PM, after dinner and an evening snack, the DON stated, "I don't see that would be a big problem." When asked if the scheduled times should have been clarified with the physician, the DON stated, "I believe the physician ordered it as he wanted it to be." When questioned about the 9/30/13 orders for Glucose 15 Gel 40 %, to give 15 grams by mouth, and the Glucagon Emergency Kit order, to give 1 gram intramuscularly for a BG < 80, if the resident was unable to swallow, the DON stated, "It was probably typed in wrong, I'll have to look it up." When asked about the order for Glucose 15 Gel 40 % for BG levels < 80, the DON stated the nurses should follow the facility's hypoglycemia policy.</p> <p>NOTE: The facility's procedure for Hypoglycemic Incidents documented, "For blood glucose levels 70 and below, or physician's guidelines, as long as resident is able to swallow (observe for gag reflex with tongue blade): a. give a rapidly absorbed carbohydrate* such as: 1) 4 oz. of orange, apple or grape juice OR 2) 6 oz. of regular soda. *These amounts are equal to 15 grams of carbohydrate."</p> <p>It was unclear if the facility was to follow the guidelines for BGs below 80 or the policy guidelines of below 70.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 38</p> <p>On 3/26/15 at 4:00 PM, the Administrator and DON were informed of the concerns regarding blood glucose issues.</p> <p>On 3/27/15 at 12:15 PM, the resident's physician stated he knew the facility had a hypoglycemia policy in place but was not involved in creating it. When asked about ordering BGs on a BID basis, the physician stated he did not order BG's BID and one of his partners must have issued that order. He stated if he ordered BGs twice per day he would order a fasting blood sugar before breakfast and then before dinner. When asked about giving Glucose Gel for a BG below 80, the physician stated he would expect nurses to use their best judgment. When asked why he would use 80 as a parameter when the American Diabetes Association listed 70-110 as normal parameters, the physician stated he used 80 as an area the nurses should look at since there could be a potential issue going on and they should recheck it at 80. For residents who have BG orders and/or sliding scale orders, but have no interventions for hypoglycemia or hyperglycemia, the physician stated the facility should implement the protocol for low BGs.</p> <p>4. During a medication pass observation on 3/24/15 at 3:17 p.m., LN #4 was observed administering insulin 2 units per sliding scale (SS) to resident #14. The LN said she had "just done" the resident's BG (blood glucose) "right before" 2 surveyors arrived and that the BG was 173. As the LN administered the insulin, she added, "This is for dinner."</p> <p>LN #4 was interviewed immediately afterward. When asked about the SS insulin in relation to</p> | F 309 | | | |

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| F 309 | <p>Continued From page 39</p> <p>meal times, LN #4 stated, "She just ate some yogurt so it's okay to give the insulin. If it was 8-10 units then I would worry but its only 2 units."</p> <p>Refer to F 333, Significant Medication Error, for details about this deficient practice.</p> <p>Note: The facility's lunch meal service was set for 12:00 to 1:00 p.m. and the dinner meal service was set for 5:00 p.m. to 6:00 p.m. Therefore, the resident's BG check was done and SS Humalog insulin was administered approximately 1 hour and 45 minutes before the evening meal was scheduled to start.</p> <p>On 3/26/15 at 2:00 pm, the DON was asked if there was a policy, procedure or guidelines for the timeframe a BG check should be done and when sliding scale insulin should be given. The DON stated, "Usually an hour window before or after the established time." When asked if she perceived a problem with insulin being given almost 2 hours before a meal, she stated, "Yeah, there's potential for a problem."</p> <p>On 3/26/15 at 6:10 pm, the Administrator, DON, and Director of Social Services were notified of the issue. The facility did not provide further information about the issue.</p> <p>5. During a medication pass observation on 3/26/15 at 11:10 am, the pharmacy label on Resident #17's Humalog insulin was noted to be different from the physician's orders.</p> <p>The label on the resident's Humalog insulin read, "Inject 8 units subcutaneously [SC] three times a day before meals." LN #1, however, administered Humalog 4 units. She said she administered 4</p> | F 309 | | | |

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| F 309 | <p>Continued From page 40</p> <p>units per the resident's sliding scale orders for a blood sugar level of 221.</p> <p>Immediately afterward, the LN was asked about the difference between the pharmacy label and the amount of Humalog insulin administered. The LN said, "It's different." The LN then looked in the computer and found the physician orders for the aforementioned SS Humalog insulin, it was dated 9/30/2013. The LN said there were no other orders for Humalog insulin.</p> <p>Refer to F 431 for details about the pharmacy labeling issue.</p> <p>On 3/26/2015 at 6:10 p.m., the Administrator, DON, and Director of Social Services were notified of the issue. The facility did not provide further information about the issue.</p> <p>6 Resident #5 was admitted to the facility on 3/18/15 with multiple diagnoses including diabetes mellitus and hypertension.</p> <p>a. Resident #5's March 2015 MAR, documented a physician's order on 3/18/15, "Kombiglyze XR Tablet Extended Release 24 hour 5-1000 MG (Saxagliptin-Metformin ER) Give 1 tablet by mouth one time a day..." and "HumaLOG KwikPen Solution Pen-injector 100 unit/ML (Insulin)...Inject as per sliding scale...subcutaneously three times a day..." The order included a BG scale on how much insulin to administer based on a range from 151 to over 351. Note: There were no orders for acceptable hypoglycemic or hyperglycemic levels or when to call a physician during hypoglycemic or hyperglycemic events.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 41</p> <p>The resident's 3/19/15 and 3/25/15 MAR documented at 11:00 AM, the resident's BG level was 421 and 587 respectively. The MAR documented the resident received 10 units Humalog insulin per the sliding scale order. There were no nurse progress notes found that the physician was notified of the elevated BG checks.</p> <p>On 3/26/15 at 3:35 PM, the DON was interviewed regarding the facility's hyperglycemia policy and she said the facility did not have a policy, but the nurses would use the "standard practice if [BG] over 400, call MD [Medical Doctor]."</p> <p>On 3/27/15 at 12:15 PM, the resident's physician was interviewed regarding the diabetic orders and asked if there were specific orders for diabetic management, such as when and what interventions should be followed. He stated, "If the facility has a protocol then follow it and then if there are questions to talk to the doctor."</p> <p>b. Resident #5's March 2015 MAR, documented a physician's order on 3/18/15, "Take blood pressure while sitting, then while standing twice on day shift and twice on evening shift..." related to hypertension.</p> <p>The resident's 3/19/15 and 3/23/15 MAR documented the blood pressure check was not taken at 8:00 AM and 12:00 PM for either day. Nurse progress notes for these days did not document a reason for the missed checks. Note: The resident did not receive anti-hypertensive medications, however, the physician had ordered the orthostatic blood pressure checks to monitor the resident's hypertension.</p> <p>On 3/26/15 at 9:30 AM, the DON was interviewed</p> | F 309 | | |

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| F 309 | <p>Continued From page 42 regarding the missed checks. She looked at the resident's MAR and stated, "I don't see anything...as to why it wasn't documented."</p> <p>On 3/26/15 at 5:30 PM, the Administrator and DON were informed of the issues. No further information was provided</p> <p>7. Resident #4 was admitted to the facility on 6/26/11 with multiple diagnoses including diabetes mellitus.</p> <p>The resident's March 2015 MAR, documented physician orders for diabetic management: * "Novolog Solution (Insulin Aspart)...Inject as per sliding scale...subcutaneously two times a day..." dated 9/30/13. The order included a BG scale on how much insulin to administer based on a range from 150 to 250; * "Metformin HCl tablet Give 500 mg by mouth two times a day ..." dated 9/30/13; * "Levemir Solution (Insulin Detemir) Inject 15 units subcutaneously at bedtime ..." dated 9/30/13; * "Glucagon ...1 MG Inject 1 dose intramuscularly as needed for hypoglycemia related to Diab[etes] ..." dated 10/28/14; * "Glucose Gel 40% ...Give 1 dose by mouth as needed for hypoglycemia related to Diab[etes] ... " Note: The orders did not include instruction to follow the facility protocol, when to administer the Glucagon or Glucose, or when to call a physician in the case of a hyperglycemic event.</p> <p>On 3/27/15 at 12:15 PM, the Medical Director was interviewed. He said he would expect nursing staff to use their best judgment if a resident's BG was less than 80. He also said the facility should follow the protocol and to talk to the resident's</p> | F 309 | | | |

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| F 309 | <p>Continued From page 43 physician if there were questions.</p> <p>8. On 3/27/15 the DON was asked to provide a list of all residents who had a diagnosis of diabetes and to indicate who received insulin per sliding scale.</p> <p>On 3/28/15 in the morning, the DON provided the requested list. Nine more residents were identified as having a diagnosis of diabetes and six of those nine received insulin per sliding scale.</p> <p>Residents #s 1, 2, 3, 4, 5, 14, 17, the nine other residents with diabetes, and any resident who could experience hypo- or hyperglycemia were in Immediate Jeopardy when the facility failed to provide adequate diabetic management as evidenced by physician's orders for hypoglycemia that did not meet accepted standards of professional practice or include parameters, or target ranges, for hypoglycemia and hyperglycemia; the lack of consistent and appropriate interventions for hypoglycemia, including a staff's attempt to administer a Glucagon injection for a BG of 63 which was refused by the resident; the lack of consistent follow-up monitoring after interventions for hypoglycemia; the failure to notify physicians of hypo- and/or hyperglycemic events; the failure to notify physicians when antidiabetic medications were held, refused or a different dose was requested/administered; BG checks and fast acting insulin that was administered almost 2 hours before a meal; failure to follow their own Hypoglycemic Incident Procedure; no procedure/guideline for hyperglycemia in place; and, a pharmacy label for insulin that was different from the physician's orders.</p> | F 309 | | | |

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| F 323 SS=E | <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 observation, record review, resident interview, the Resident Group Interview, and staff interview, it was determined the facility failed to ensure: *harmful chemicals were secured; *adequate supervision for residents who wandered; *fall interventions were in place after falls; *fall interventions were followed; and, *public restrooms contained call light cords and/or safety grab bars.</p> <p>This was true for 1 of 1 therapy storage closets, 1 of 1 therapy housekeeping closets, 1 of 2 dining rooms, 1 of 2 (#1) residents reviewed for falls, 1 of 7 public restrooms, and 1 of 1 unlocked employee only restroom. These failures created the potential for harm for any: *independently mobile, cognitively impaired resident who could access the unsecured chemicals and hazards; *residents with unwanted co-residents wandering into their rooms who could become violent; *residents who fell in the facility and could sustain injury without fall interventions in place; and, *residents or visitors who accessed public and unlocked employee restrooms who required</p> | F 323 | <p>1. Paint cans were removed immediately from the therapy hallway storage room and auto lock door knob installed 3/23/15.</p> <p>Unsecured chemical was removed immediately from the therapy housekeeping closet and auto lock door knob installed on 3/23/15.</p> <p>Resident #25 passed away 2/20/15.</p> <p>Resident #24 was issued a 30 day discharge notice and 1:1 initiated for intrusive wandering on 4/22/15. Resident was discharged to another facility on 4/27/15.</p> <p>Public restroom door near the chapel had a lock installed on 3/31/15.</p> <p>Employee restroom had a lock installed on 3/31/15.</p> <p>Red bucket filled with sanitizer was removed from public dining area immediately on 3/25/15.</p> <p>Resident #1 care plan was updated to include non-</p> | |

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| F 323 | <p>Continued From page 45 assistance with grab bars or call lights and did not receive it. Findings included:</p> <p>1. On 3/23/15 from 2:25 to 2:30 PM, the following was observed: -The storage room in the therapy hallway was unlocked and on the top shelf were 2 one gallon cans of exterior barn and fence paint. The cans documented, "Harmful if swallowed." -An unlocked housekeeping closet in the therapy alcove hallway had a spray bottle of Limeaway spray cleaner which documented, "Caution eye and skin irritant."</p> <p>On 3/23/15 at 2:36 PM, the Environmental Service Director was shown the cans of paint and asked if the paint should be stored there, he stated, "Absolutely not." He was then shown the Limeaway and he said the housekeeping room door should have been locked. He then locked the housekeeping closet door and removed the paint from the storage closet.</p> <p>On 3/23/15 at 4:55 PM, the Administrator, DON and Social Worker were informed of the hazard issues. No further information was provided by the facility.</p> <p>2. Lack of supervision for residents who wandered:</p> <p>Documentation:</p> <p>a. On 12/16/14, Resident Council Meeting minutes documented: "Resident concern (1) They were concerned about the integration of Helping Hands Residents into the general population; [Resident Name] said when [Resident #25]</p> | F 323 | <p>pharmacological interventions for anxiety.</p> <p>2. All residents have the potential to be affected by these practices.</p> <p>3. Facility inspection for unsecured harmful chemicals, call lights and grab bars were added to TBLS monthly program review.</p> <p>Fall scene investigation will be completed at time of fall to ensure interventions are in place, followed, and care plan updated.</p> <p>Public restrooms have been placed on TELS inspection checklist to ensure call light cords and/or safety grab bars are in place.</p> <p>All staff were in-serviced on changes to the above processes 4/24/15.</p> <p>4. Monitoring will be completed through staff and chart review, direct observation of environment, and resident interviews regarding observation</p> | |

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| F 323 | <p>Continued From page 46</p> <p>wandered into her room she confronted her. [Resident #25] acted like she was going to hit her. [Resident Name] said she wasn't here to be a babysitter; [Resident Name] found [Resident #25] on her bed; and, [Resident Name] reported [Resident #25] wandering into his room and trying to lay down on his bed.</p> <p>On 2/17/15, Resident Council Meeting minutes documented: "A resident expressed concern about a particular resident entering her room. Another resident expressed concern over the same forcing herself into the horse racing game of [sic] 2/17/15. This resident related that she was admonished for objecting to the aforementioned resident's intrusion and stated at the meeting that she only has so much patience. Another resident described inappropriate behavior and unwanted touching by this same resident during his TV time; Residents resent the unrestricted entry into their rooms when they are occupying them and worry about entry into their rooms when they are not present; and, The residents have unilaterally agreed that they are tired of hearing "We'll take care of it" and "We'll see what we can do" as a blanket response to their concerns."</p> <p>On 3/17/15, Resident Council Meeting minutes documented: "Residents entered into a round robin discussion on the subject of troublesome residents. They express concerns about room intrusions, inappropriate touching...boundaries being violated, and above all else, unresponsiveness</p> | F 323 | <p>of wandering behavior. Results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Staff development coordinator or designee will audit environment for chemicals, care plan interventions for falls and fall scene investigations, restroom safety equipment weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 323 | <p>Continued From page 47</p> <p>from management. Having related that "We're working on it" and "I can't tell you anything about it" are inadequate responses, the residents are now seeking alternative answers; and, They are frightened of intruders...they fear physical harm from intruders that believe the residents are in the wrong room when it is the intruder that is in the wrong room."</p> <p>b. On 1/26/15, Resident/Administrative meeting minutes with the administrator present, documented: "Wandering residents into others r[oo]ms being woken by other residents, residents calling out 24 h[ou]rs a day; [Administrator] went over reasons why Helping Hands was closed; and, [Administrator] will seek out residents with concerns/complaints individually."</p> <p>c. On 3/26/15 a list of 13 residents was received, including Resident #s 1, 6, 8 and Random Resident #s 13, 17, 20, 21, and 24, who resided in the facility and had wandering behaviors.</p> <p>d. Resident #24's care plan documented: -12/23/14, "[Resident #24] has potential for elopement R/T [related to] wandering, exit seeking behavior."</p> <p>The resident's care plan documented interventions which included: -12/23/14, "Check placement of Wanderguard every shift." and, -1/18/15, "Intervene as necessary to protect the rights and safety of others. Approach in a calm manner. Divert attention. Remove from situation and take to alternate location as needed."</p> | F 323 | | |

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| F 323 | <p>Continued From page 48</p> <p>Resident Interviews:</p> <p>a. On 3/24/15 at 1:00 PM, during the Resident Group Interview, 9 out of 11 residents present, said the residents who wandered had been an issue. Residents in the group made the following statements: -"I can't go to bed until they [residents who wander] go to bed."; -"We feel like babysitters;" -"It's our home, but it does not feel like it's our home anymore;" and, -"It's that small handful that are problems." The residents also said the issue is an everyday occurrence and the facility did not have enough staff to manage the situation. Four of the residents said they each had a person who wandered, who followed them throughout the facility, and into their rooms. They also said they have had to place stop signs on their doors to help keep the residents who wandered out of their rooms. Refer to F 353 regarding lack of staffing.</p> <p>b. On 3/25/15 at 1:00 PM, Resident #4 was interviewed regarding a resident who wandered into her room a few days prior. She said her door was closed and a female resident in a wheel chair, came into Resident #4's room uninvited. The other resident became stuck in the room, could not back out, and kept yelling, "Help" and "Ma'am." Resident #4 said she had to use her call light and wait for staff to come in order to get the resident to leave. She said the incident "made me mad."</p> <p>c. On 3/26/15, Resident #2 was interviewed about privacy concerns. He said there have been issues with other residents wandering into rooms, but he</p> | F 323 | | | |

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| F 323 | <p>Continued From page 49</p> <p>said he kept his door closed to help keep those residents out.</p> <p>Observations:</p> <p>On 3/27/15 at 2:15 PM, nine stop signs were observed either attached to resident doors or attached to the door frames with Velcro straps.</p> <p>Staff Interviews:</p> <p>a. On 3/26/15 at 10:20 AM, the DON was interviewed regarding residents who wandered. She said Resident #24 frequently wandered into other residents' rooms. When asked what the facility did to keep her from wandering into other residents' rooms, she said staff redirected the resident, provided one-on-one time for the resident, added stop signs to other resident's room doors, and provided 15 minute checks for when the resident was at risk for falls. When asked if there were 15 minute checks for wandering, the DON said staff had only done 15 minute checks on and off, as an intervention for falls. When asked if the resident became violent with other residents, she said the resident was only verbally aggressive towards staff.</p> <p>b. On 3/26/15 at 4:19 PM, CNA #6 was interviewed. When asked about residents who wandered into other residents' rooms, she stated it happened "a lot...About 10 to 20 times a day." She said staff usually had to intervene to redirect those residents out of the room.</p> <p>c. On 3/26/15 at 4:45 PM, the Social Worker was interviewed and said she was aware of three residents, including Resident #24, who frequently wandered into other residents rooms. When</p> | F 323 | | | |

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| F 323 | <p>Continued From page 50</p> <p>asked what steps the facility had taken to reduce the wandering behaviors, she said staff would redirect and reassure them, provide supervision and diversionary activities, and had added stop signs to resident room doors. When asked what would happen if all three residents identified wandered at the same time on a shift when there was limited staff, such as night shift, she stated, "It can be and has been a problem."</p> <p>d. On 3/26/15 at 4:55 PM, CNA #7 was interviewed and said residents wandered into rooms "almost daily." She said staff would then redirect them or show them where their room was.</p> <p>3. On 3/24/15 at 8:30 AM, the public restroom near the chapel was observed unlocked and only contained a single call light cord in 1 of 2 toilet stalls. The Housekeeping Supervisor was interviewed and she acknowledged one stall was missing a call light cord and said the restroom was kept unlocked because it was a public restroom.</p> <p>On 3/27/15 at 9:25 AM, during the environmental tour, the Environmental Service Director was shown the stall in the unlocked restroom. He stated, "If we're going to leave it open it needs one [more call light cord]."</p> <p>4. On 3/25/15 at 11:00 AM and throughout the survey, an "employee only" labeled restroom was observed unlocked next to nursing station number three. The restroom did not contain a call light cord or assistive grab bars.</p> <p>On 3/27/15 at 9:20 AM, during the environmental tour, the Environmental Service Director was</p> | F 323 | | | |

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| F 323 | <p>Continued From page 51 shown the unlocked restroom and he stated, "We're gonna lock it."</p> <p>X. On 3/25/15 at 5:30 PM, during the dinner observation in the Idaho Dining Room, a red bucket filled with Multi-Quat Sanitizer and water was observed sitting on the counter located to the immediate right of the main entrance of the dining room. Residents were observed in the dining room while the red bucket filled with the Quat Sanitizer was unsupervised. DA #16 was observed with her back to the bucket, waiting by the food service station, to deliver resident meals. The situation presented the potential for harm to any ambulatory cognitively impaired resident who could have accessed the bucket.</p> <p>On 3/25/15 at 5:35 PM, DA #16 stated she placed the bucket filled with Multi-Quat on the counter, and tested it at 300 PPM (parts per million) before she brought it out of the kitchen. She stated when she started working at the facility, she was taught every night to put a bucket of Quat Sanitizer on the counter to help with cleanup after dinner. Note: The Material Safety Data Sheet (MSDS) for the Multi-Quat Sanitizer documented the product was a dangerous chemical and caused digestive tract, eye and skin burns. In addition, the product caused respiratory tract irritation and documented, "Do not ingest. Do not get in eyes, on skin or on clothing. Avoid breathing vapors, spray or mists. Keep container closed. Use only with adequate ventilation. Wash thoroughly after handling."</p> <p>On 3/25/15 at 5:40 PM, when asked about the unattended bucket of Multi-Quat on the counter, which could potentially affect any resident in the</p> | F 323 | | |

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| F 323 | <p>Continued From page 52</p> <p>dining room, the DDS stated, "I don't know what resident would get into it, they use it to clean up messes. The department heads have requested it be out here and is something we have always done." The DDS stated she would move the bucket.</p> <p>On 3/26/15 at 6:10 PM, the Administrator and the DON were made aware of the hazardous concern found in the dining room. No additional information was provided.</p> <p>X. Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>Resident #1's Annual MDS assessment, dated 10/10/14, and Quarterly MDS assessment, dated 1/8/15, documented the resident was severely cognitively impaired with a BIMS score of 3, needed extensive assistance of at least 2 persons for bed mobility, toilet use, personal hygiene, locomotion off unit and bathing.</p> <p>The resident's care plan for falls, initiated on 10/29/13 and revised on 1/20/14, documented the resident was at risk for falls related to dementia, confusion, gait/balance problems, incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs, wandering, and history of falls. The fall care plan interventions in place prior to the resident's first fall on 12/31/14, documented:</p> <p>**Educate the resident and family on safety of assistive device walker;</p> <p>*Encourage [name of resident] to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: walk in corridor with walker and one assist daily;</p> | F 323 | | | |

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| F 323 | <p>Continued From page 53 and, *Ensure that [name of resident] is wearing appropriate footwear when ambulating or mobilizing in w/c; and, Monitor [name of resident] for significant changes in gait, mobility, standing/sitting balance and lower extremity joint function."</p> <p>Record review of the Incident Reports (IR) documented Resident #1 had three falls without injury between 12/31/14 and 2/21/15.</p> <p>An IR dated 12/31/14 at 7:30 AM, documented the resident was found on the floor in a supine position, slightly raised up as if trying to get up. The resident reported to staff she was trying to find her daughter. The resident's shoes were on the w/c which was by her side with brakes unlocked. The IR documented the resident was confused and had gait imbalance issues.</p> <p>An IR dated 2/17/15 at 2:50 PM, documented the resident was found on the floor, lying on her back, next to her bed, attempting to self-transfer from bed to wheelchair. The resident reported to staff she was trying to get up to go to the bathroom. The IR documented the resident was confused. A Fall Risk Evaluation, dated 2/17/15 at 2:50 PM, documented, "Resident is being evaluated following a fall in the area of her bed when she was self-transferring. She was found to be wet when found on the floor so she may have been responding to a need to toilet...received Ativan @ [at] 1:30 PM and again at 7:40 PM. Unable to tell what non-pharmacological interventions were used prior to medication given...Resident has dementia and her short term memory is impaired as well as safety awareness and decision making capacity. Resident in on a toileting schedule to be</p> | F 323 | | | |

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| F 323 | <p>Continued From page 54 toileted Q [every] 2 hours during daytime hours..."</p> <p>An IR dated 2/21/15 at 12:50 PM, documented the resident was found sitting on the floor next to her bed, her wheelchair brakes were not locked which was a predisposing environmental factor, and she may have been attempting to self-transfer. The IR documented the resident had impaired memory.</p> <p>No documentation was found in the Incident Reports or in the fall care plan that interventions had been added to prevent future falls following the 12/31/14, 2/17/15 or 2/21/15 incidents.</p> <p>A Physical Device and Restraint Assessment, dated 2/26/15 at 10:54 AM, documented an intervention to add anti-reverse brakes to the resident's wheelchair to keep from sliding backwards when the resident tried to seat herself. The assessment documented, "She forgets to lock the [wheel]chair due to cognitive impairment and forgets to call for assistance to get in it. This will provide a safe device for use by this resident."</p> <p>The wheelchair anti-reverse brakes were not observed on the resident's wheelchair, which was located at the foot of the resident's bed, during the following observations: *3/23/15 at 4:40 PM; *3/24/15 at 8:50 AM; 10:05 AM; 11:25 AM; 3:05 PM; and, 4:00 PM.</p> <p>On 3/27/15 at 3:35 PM, LN #8 was asked what interventions were added to the fall care plan after the resident fell on 12/31/14, 2/17/15 and 2/21/15. LN #8 stated, "I don't see anything." When asked if a root cause had been determined for the 12/31/14 fall, LN #8 shook her head from</p> | F 323 | | | |

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| F 323 | Continued From page 55 side to side and stated, "Not on this report, no." When asked if a root cause had been determined for the 2/17/15 fall, LN #8 stated, "I suggested the resident needed to have the toileting plan looked at and suggested that Ativan given 1-1/2 hour earlier might have attributed to the fall." LN #8 stated, "I do an evaluation after a resident falls. Each day I look through the falls, then I look at the care plan to see what is in place. I don't wait for anyone to tell me, I try to fix it myself. When IRs are reviewed, I am not involved." When asked who reviewed resident falls, LN #8 stated, "The DON as far as I know. The case managers aren't asked to be involved in the discussion immediately after a fall. We use to be until early last fall." When asked about a root cause and interventions for the 2/21/15 fall, LN #8 stated, "I suggested anti-reverse brakes, but it wasn't added to the care plan though." LN #8 stated the resident did not remember to lock the wheelchair brakes. When asked if the care plan had been revised with the new intervention, LN #8 stated, "No, [but] it should have been." On 3/27/15 at 5:30 PM, the Administrator and the DON were made aware of the concern regarding falls. No additional information was provided. | F 323 | | | |
| F 325 SS=G | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and | F 325 | | | |

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| F 325 | <p>Continued From page 56</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were not harmed through severe weight loss. This was true for 1 of 10 residents (#1) sampled for weight loss and resulted in harm when Resident #1 lost 11-percent of her body weight in a three month period, and 19-percent of her body weight over six months. Findings included:</p> <p>Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>The annual MDS assessment, dated 10/10/14, documented the resident had severe cognitively impairment with a BIMS score of 3, needed supervision, one person assistance when eating, and weighed 143 lbs.</p> <p>The quarterly MDS assessment, dated 1/8/15, documented the resident had severe cognitively impairment with a BIMS score of 3, needed setup help only to eat, and weighed 127 lbs.</p> <p>The ADL Care Plan, initiated 10/17/13 and revised on 4/29/14, documented an intervention to remind, cue and provide assistance to the resident as needed to eat.</p> <p>The Nutritional Care Plan, initiated on 10/18/13,</p> | F 325 | <ol style="list-style-type: none"> 1. Resident #1 physician notified of current weight on 3/30/15. Resident was re-assessed 4/22/15 comorbidities reviewed and plan put in place to ensure cueing with dining. Physician assessment and explanation for the diagnosis of expected and unavoidable weight loss completed 4/22/15. Care plan updated to include dining choices 4/24/15. Swallow evaluation requested 4/17/15. Speech therapy evaluation requested 4/27/15. 2. Residents with weight loss or at risk for weight loss have the potential to be affected by this practice. 3. Licensed nurses will monitor documentation of intake and provide interventions to meet caloric needs for residents with or at risk for weight loss. Recommendations from speech therapy will be scanned into resident record and routed to DNS and Care manager. <p>Licensed nurses were in-serviced on changes to this process to meet</p> | | |

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| F 325 | <p>Continued From page 57</p> <p>documented the following interventions: *Invite resident to activities that promote additional intake. Family encouraged to eat meals with resident, revised 1/6/14; *Prefers to sit in her room or with front office staff during meals/snacks; *Offer meals in the dining room each meal, offer walk to dine; *Often prefers to eat in her room or with office staff, revised 10/22/14; *Assist with obtaining special equipment as needed. Plastic spoon with meals. Offer finger foods, revised 1/14/15; *Snack/food #3 offer fluids and a finger food for snacks, revised 1/26/15; *Weigh weekly. MD states weight loss expected and unavoidable, revised 2/11/15; Note: The record did not include an assessment or explanation for the diagnosis of "expected and unavoidable." *Give fortified foods per dietary plan. Offer foods one at a time, revised 2/18/15; and, *Snack/food #1 mandarin oranges with breakfast. Resident will also be offered bran, prune, applesauce mixture with breakfast to promote bowel regularity daily, revised 2/18/15.</p> <p>The resident's Weights Summary Report documented the following weights:</p> <table border="0"> <tr> <td>*10/18/14</td> <td>142.5</td> <td>*1/4/15</td> <td>127</td> </tr> <tr> <td>*10/26/14</td> <td>140</td> <td>*1/10/15</td> <td>127.3</td> </tr> <tr> <td>*11/1/14</td> <td>140.2</td> <td>*1/19/15</td> <td>127</td> </tr> <tr> <td>*11/7/14</td> <td>135</td> <td>*1/25/15</td> <td>126.2</td> </tr> <tr> <td>*11/15/14</td> <td>133.2</td> <td>*2/1/15</td> <td>116</td> </tr> <tr> <td>*11/23/14</td> <td>125.6</td> <td>*2/8/15</td> <td>114</td> </tr> <tr> <td>*11/29/14</td> <td>126</td> <td>*2/14/15</td> <td>113.4</td> </tr> <tr> <td>*12/8/14</td> <td>125.5</td> <td>*2/21/15</td> <td></td> </tr> </table> | *10/18/14 | 142.5 | *1/4/15 | 127 | *10/26/14 | 140 | *1/10/15 | 127.3 | *11/1/14 | 140.2 | *1/19/15 | 127 | *11/7/14 | 135 | *1/25/15 | 126.2 | *11/15/14 | 133.2 | *2/1/15 | 116 | *11/23/14 | 125.6 | *2/8/15 | 114 | *11/29/14 | 126 | *2/14/15 | 113.4 | *12/8/14 | 125.5 | *2/21/15 | | F 325 | <p>the individual resident's needs on 4/9/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Registered dietitian or designee will audit; care plan, current weight, cueing and dining, physician assessment and explanation for diagnosis, speech therapy recommendations weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |
| *10/18/14 | 142.5 | *1/4/15 | 127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *10/26/14 | 140 | *1/10/15 | 127.3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *11/1/14 | 140.2 | *1/19/15 | 127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *11/7/14 | 135 | *1/25/15 | 126.2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *11/15/14 | 133.2 | *2/1/15 | 116 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *11/23/14 | 125.6 | *2/8/15 | 114 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *11/29/14 | 126 | *2/14/15 | 113.4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *12/8/14 | 125.5 | *2/21/15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

PRINTED: 04/15/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 | |
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| F 325 | Continued From page 58 112.2 *12/13/14 124.1 *3/1/15 111.6 *12/21/14 126.2 *3/7/15 112.6 *12/27/14 127.5 *3/14/15 111.5 *3/21/15 115.4 Resident #1 was observed throughout the survey week of 3/23/15 appeared thin and cachectic (loss of weight and muscle mass). On 3/24/15 at 9:16 AM, CNA #5 was observed delivering a breakfast tray to Resident #1's BST (bedside table). CNA #5 awakened the resident, asked if she needed anything else and left the room. The resident leaned up on her left elbow, ate the mandarin oranges and drank approximately half of her milk. She did not touch the scrambled eggs, potatoes, or bacon, or drink the milk shake, which was on the breakfast tray. The resident lied down and closed her eyes. CNA #5 was not observed to remind, cue, or assist the resident to eat or offer foods one at a time as care planned. On 3/24/15 at 10:05 AM, a staff member came into the resident's room and asked if she had been served breakfast. The resident replied, "Yes." The staff member asked if the resident wanted anything else until noon, and the resident replied she was fine. On 3/24/15 at 10:25 AM, a chocolate shake with a straw was observed on the resident's BST. The resident was in bed sleeping. On 3/24/15 at 11:25 AM, the resident was awake in bed with the chocolate shake, which was still | F 325 | | |

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| F 325 | <p>Continued From page 59</p> <p>full, and a full water pitcher on the BST.</p> <p>On 3/24/15 at 12:45 AM, the resident remained in bed, the chocolate shake and water jug remained on the BST and were both full. The hall lunch trays had not been delivered.</p> <p>The meal monitor for 3/24/15 documented the resident ate 26-50% of breakfast at 9:03 AM, refused lunch at 1:32 PM, ate 0-25% (snack) at 2:56 PM and refused the evening snack.</p> <p>On 3/25/15 at 8:35 AM, the RD provided a nutrition timeline and stated eating was more of a social aspect for Resident #1 and she ate best at lunch or when family were present. She stated the resident needed encouragement to go to the dining room. When asked about the intervention to remind, cue and assist the resident as needed to eat, the RD stated, "I would expect a CNA to assist in cueing and reminding the resident to eat. Absolutely, since she has had significant weight loss since Christmas. Actually, her weight loss started in November."</p> <p>On 3/25/15 at 9:00 AM, the OM stated Resident #1 liked her and they normally had lunch together, but she hadn't seen her the day before. The OM stated the resident, who had worked in an office, liked to watch for her daughter or son to arrive, and liked the activity. Note: There was no documentation of a plan for the resident to have her meals in the office when the OM was unavailable.</p> <p>On 3/25/15 at 4:45 PM, LN #4 was observed asking the resident if she wanted a can of Ensure and the resident requested Vanilla flavor.</p> | F 325 | | | |

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| F 325 | <p>Continued From page 60</p> <p>On 3/25/15 at 5:30 PM, the resident was observed in bed with a can of Vanilla Ensure; a water pitcher on her BST was not within reach.</p> <p>On 3/25/15 at 6:10 PM, LN #4 was asked if the resident was able to reach the Ensure and water pitcher on the BST. She stated, "No, the resident can't reach it. Usually the resident needs to be encouraged and when I walk by I tell her to take a sip." LN #4 then moved the BST closer to the resident's bed. The resident sat up in bed and took a drink of the Ensure. Note: Once the BST with the water pitcher and Ensure was moved within the resident's reach, she took a drink.</p> <p>The meal monitor for 3/25/15 documented the resident ate 0-25% of breakfast at 9:03 AM, 0-25% of lunch at 1:00 PM, and did not contain documentation for the evening meal or the evening snack.</p> <p>On 3/26/15 at 9:05 AM, the resident was observed sitting in her WC in the dining room being assisted to eat by a CNA. The surveyor observed the resident ate approximately 75% of her meal.</p> <p>On 3/26/15 at 12:30 PM, the resident was observed sitting in her WC with a lunch tray in the office eating lunch with the OM.</p> <p>The meal monitor for 3/26/15 documented the resident ate 26-50% of her breakfast at 10:36 AM, ate 51-75% of her lunch at 12:43 PM and refused food/supplement at 2:51 PM and 9:52 PM. The evening snack monitor documented the resident ate 0-25% at 9:58 PM. Note: When assisted to eat, the resident showed</p> | F 325 | | | |

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| F 325 | <p>Continued From page 61</p> <p>an increased percentage in the amount of food eaten, as evidenced by the 26-50% eaten at breakfast, and when eating lunch with the OM, the resident ate 51-75%.</p> <p>Review of the physician's progress notes revealed: *10/19/14-The resident weighed 143 lbs. and weight was stable; *12/15/14-The resident weighed 124 lbs., had previously weighed in the 140's, and would be put on a weight assessment program; and, *2/7/15-The resident weighed 116 lbs., was down 11 lbs. (No comparative date or weight documented), and would again discuss with staff steps taken to control her weight. Note: No documentation was found which defined a weight assessment program or that one was implemented. No documentation was found of a discussion with staff on how to control the resident's weight.</p> <p>Review of the Medication Review Report for March 2015 (recapitulation orders), documented an order, dated 11/12/14, for 1 can of Ensure daily with dinner related to diabetic management and an order, dated 12/16/14, for House Supplement three times a day for weight loss, poor appetite/intake, offer 240 cc (cubic centimeters) house supplement with snacks.</p> <p>Note: No documentation was provided by the facility that it was tracking the success of interventions which had been attempted. No documentation was provided the speech therapist had been involved or who recommended the intervention to offer foods one at a time. Additionally, no documentation was found in the resident's care plan of the RD's recommendation</p> | F 325 | | | |

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| F 325 | <p>Continued From page 62</p> <p>of adding chocolate with meals, that staff knew of the RD's recommendation or when it was discontinued. During the survey process, chocolate was not observed to be served to the resident.</p> <p>On 3/25/15 at 9:15 AM, the RD provided a Nutrition Timeline for the resident and stated on 11/15/14 the resident weighed 133.2 lbs. and had significant weight loss (6.5%) based on the 30 day weight of 142.5 lbs. taken on 10/11/14. She stated the resident was placed on Ensure, pudding, Nutrition At Risk (a weekly interdisciplinary meeting to address weight loss), along with lab work. On 12/2/14, the RD recommended chocolate with meals to help stimulate the resident's appetite. On 12/15/14, the RD stated that chocolate with meals as an appetite stimulant had not increased her oral intakes but the resident wanted to continue taking chocolate with meals. On 12/15/14, the resident's physician approved the RD recommendations to increase the Ensure to TID (three times daily). The resident had some weight gain in January with three weeks of stable weight at 127 lbs. However, the resident lost 10 lbs. in one week, recording a weight of 126.2 lbs. on 1/25/15 and 116 lbs. on 2/1/15. She stated the resident's weight dropped another 2 lbs. on 2/8/15.</p> <p>The RD faxed a communication to the resident's physician on 2/9/15 regarding the weight concern, and informed the physician that the resident was not interested in eating and not responding to nutrition interventions. She asked the physician the following numbered questions: "#1) Will you address her weight loss? #2) Would you say that her weight loss is expected and unavoidable? Thanks!" The physician's faxed response</p> | F 325 | | | |

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| F 325 | <p>Continued From page 63</p> <p>documented, "Weight loss is expected and unavoidable." The RD did not provide a summary of the current interventions or make the physician aware of what interventions had been tried before asking the physician for a weight loss diagnosis of expected and unavoidable. In response to the faxed request from the RD on 2/9/15, the physician did not document why weight loss was unavoidable. Additionally, his progress notes did not address unavoidable or expected weight loss concerns.</p> <p>A progress note on 2/25/15 at 2:38 PM, by the LSW, documented, "MD states that he will address pain relief as a potential reason for decline in weight loss." This progress note was nearly three weeks after the 2/9/15 faxed response by the physician in which he responded to the RD's request for a diagnosis of "expected and unavoidable" weight loss. No documentation was found which indicated the physician investigated pain relief as a potential reason for the resident's weight loss.</p> <p>On 3/25/15 at 9:15 AM, the RD stated she felt the facility had done all it could to prevent weight loss. The RD was made aware of the observations where the resident had the food tray placed on her BST, and had not been reminded, cued or received assistance as needed to eat. The RD shook her head from side to side. The surveyor explained the facility identified interventions, but did not ensure the resident received the help she needed. The RD was unable to explain why the interventions identified by the facility were not carried out during the surveyor's observations.</p> <p>On 3/25/15 at 9:55 AM, CNA #5 stated breakfast</p> | F 325 | | | |

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| F 325 | <p>Continued From page 64</p> <p>hall trays were normally delivered between 9:30-10:00 AM and she had setup Resident #1's breakfast tray on 3/24/15. She stated the resident ate all of her mandarin oranges and most of her milk. She stated the resident didn't really eat and that it was she who charted on the meal monitor. She stated she delivered the lunch tray and set it up as well. She stated Resident #1 wasn't hungry and didn't eat anything for lunch. CNA #5 stated every CNA charted differently, with most staff charting what the resident ate off her plate. However, CNA #5 stated, she charted the percentage of what the resident ate of everything, not just on her plate. CNA #5 stated she charted the resident ate 25% so she picked 0-25%. When shown the meal monitor where she charted 26-50%, CNA #5 stated Resident #1 ate only the mandarin oranges. When asked if she ever stayed in the room and reminded, cued or assisted the resident to eat, CNA #5 stated, "She is independent to eat, unless they changed it and didn't tell me."</p> <p>Record review of the Kardex Report used by CNA's and provided on 3/25/15, documented the resident, "Requires reminding, and cueing, assistance as needed to eat."</p> <p>On 3/27/15 at 3:35 PM, LN #8 stated the staff did not often cue, remind, or assist the resident to eat. At 5:10 PM, LN #8 stated Resident #1 had lost a substantial amount of weight. She stated the resident's physician was aware of her severe weight loss and had mentioned it to LN #8 but, "he didn't give us any advice."</p> <p>The facility failed to ensure the resident was reminded, cued, and assisted to eat as needed as care planned. Resident #1 experienced severe</p> | F 325 | | | |

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| F 325 | Continued From page 65 weight loss of 9.3 lbs. or 6.5% in one month, from 10/18/14 to 11/15/14. She continued to experience severe weight loss of 15.5 lbs. or 11% in three months and 27.1 lbs. or 19% in six months. No documentation was found which defined a weight assessment program or that one was implemented. No documentation was found of a discussion with staff on how to control the resident's weight. No documentation was provided by the facility that it was tracking the success of interventions which had been attempted. | F 325 | | | |
| 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure residents were adequately hydrated. This was true for 1 of 3 sampled residents (#1) reviewed for dehydration. This failure had the potential to cause physical harm if residents with dementia forgot to drink fluids and became dehydrated. Findings included: Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes | F 327 | 1. Resident # 1 hydration needs were reassessed by registered dietitian on 4/22/15. Care plan updated to include assistance with hydration by cueing and providing assistance, and having drinks within reach on 4/23/15. 2. Residents requiring assistance with hydration or have risk for dehydration have the potential to be affected by this practice. 3. Licensed nurses will monitor documentation of intake and provide interventions to meet | | |

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| F 327 | <p>Continued From page 66</p> <p>mellitus II, anxiety, depression and dementia.</p> <p>The quarterly MDS assessment, dated 1/8/15, documented the resident was severely cognitively impaired, needed setup help to eat, and weighed 127 lbs.</p> <p>The resident's care plan did not document a care plan for hydration. The ADL Care Plan, initiated 10/17/13 and revised on 4/29/14, did not address the need to be reminded, cued, and provided assistance to drink fluids.</p> <p>On 3/24/15 the surveyor made the following observations of Resident #1: *10:25 AM, the resident was observed to have a full carton of chocolate shake with a straw on her BST (bedside table); *11:25 AM, a full carton of chocolate shake was observed to be on the resident's BST; and, *12:45 AM, had a full water pitcher and a full chocolate shake were on the BST.</p> <p>On 3/25/15 the surveyor made the following observations of Resident #1: *3:05 PM and 4:00 PM, the resident was observed to be lying in bed with a full water pitcher on her BST, however, staff were not observed to remind, cue or provide assistance to the resident to drink fluids; *4:45 PM, LN #4 offered the resident a milkshake (Ensure). The resident responded she would like a Vanilla; and, *5:30 PM, the resident had a can of Vanilla Ensure with a straw on her BST and a full water pitcher, which was not within reach. The surveyor asked the resident if she had drank any of her Ensure and she stated, "I don't really know."</p> | F 327 | <p>hydration needs for residents with or at risk for dehydration.</p> <p>Nursing staff was in-serviced on changes to this process to meet the individual resident's hydration needs on 4/9/15.</p> <p>4. Monitoring will be done through direct observation of resident, care plan review, and fluid intake review. Results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit hydration documentation weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/30/2015 | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|----------------------|--|--------|----------------|----------|--------|----------------|----------|--------|------------------|----------|--------|----------------|----------|--------|----------------|----------|--------|----------------|----------|--------|----------------|-------|--|--|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 | | | | | | | | | | | | | | | | | | | | | | | | | |
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| F 327 | <p>Continued From page 67</p> <p>On 3/25/15 at 6: 10 PM, LN #4 was asked, by the surveyor, if the resident was able to reach the can of Ensure on the BST. LN #4 stated, "No, the resident can't reach it. Usually the resident needs to be encouraged and when I walk by, I tell her to take a sip." LN #4 then moved the BST closer to the resident who sat up and took a drink.</p> <p>Federal Guidance at F-327 documented a formula for determining baseline daily fluids related to a resident's body weight. The calculated amount of daily fluids needed for sufficient fluid intake to maintain proper hydration and health, according to the resident's weight of 111.5 lbs., taken on 3/16/15, was 1,521 ccs (cubic centimeters). Record review of the amount of fluids consumed with each meal totaled with the amount of the House Supplements, Ensures, and/or Milkshakes offered to the resident equaled:</p> <table border="0"> <tr> <td>*3/16/15</td> <td>460 cc</td> <td>1,061 cc deficit</td> </tr> <tr> <td>*3/17/15</td> <td>710 cc</td> <td>811 cc deficit</td> </tr> <tr> <td>*3/18/15</td> <td>660 cc</td> <td>861 cc deficit</td> </tr> <tr> <td>*3/19/15</td> <td>240 cc</td> <td>1,281 cc deficit</td> </tr> <tr> <td>*3/20/15</td> <td>890 cc</td> <td>631 cc deficit</td> </tr> <tr> <td>*3/21/15</td> <td>660 cc</td> <td>509 cc deficit</td> </tr> <tr> <td>*3/22/15</td> <td>720 cc</td> <td>801 cc deficit</td> </tr> <tr> <td>*3/23/15</td> <td>640 cc</td> <td>881 cc deficit</td> </tr> </table> <p>Note: The total amount of cc for 3/16 - 3/23 totaled 6,836 cc which is equal to a one gallon and three quart deficit.</p> <p>On 3/27/15 at 12:40 PM, the RD was shown the resident's total ccs consumed with her meal, the RD stated, "They are very low. I would look at nursing MARs for additional fluid fluid intake for supplements and snacks." When asked if anyone was monitoring fluid takes for the resident, the</p> | *3/16/15 | 460 cc | 1,061 cc deficit | *3/17/15 | 710 cc | 811 cc deficit | *3/18/15 | 660 cc | 861 cc deficit | *3/19/15 | 240 cc | 1,281 cc deficit | *3/20/15 | 890 cc | 631 cc deficit | *3/21/15 | 660 cc | 509 cc deficit | *3/22/15 | 720 cc | 801 cc deficit | *3/23/15 | 640 cc | 881 cc deficit | F 327 | | |
| *3/16/15 | 460 cc | 1,061 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *3/17/15 | 710 cc | 811 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *3/18/15 | 660 cc | 861 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *3/19/15 | 240 cc | 1,281 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *3/20/15 | 890 cc | 631 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *3/21/15 | 660 cc | 509 cc deficit | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| F 327 | Continued From page 68 RD stated, "That would be a nursing question." On 3/27/15 at 5:10 AM, LN #8, who was also the resident's Case Manager, was shown the above calculated daily fluid totals and stated, "That is not enough." On 3/27/15 at 5:50 PM, the Administrator and DON were made aware of the hydration concern. No further information was provided by the facility. | F 327 | | | |
| F 328 SS=D | 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 observation, resident and staff interview, record review, and policy and procedure review, it was determined the facility failed to provide a policy and procedure for CPAP (continuous positive airway pressure) Therapy which included direction for care and cleaning. This was true for 1 of 7 (#7) residents sampled. Additionally, the care plan did not include the correct liter flow for the CPAP; this failure created | F 328 | 1. Resident #7 AVAP manufacturer directions for care and cleaning were reviewed and orders revised on 3/31/15. AVAP liter flow care plan and orders were updated on 3/26/15. 2. Residents utilizing CPAP/AVAP have the potential to be affected by this practice 3. Upon admission individual CPAP/AVAP manufacturer instructions will be obtained and placed with equipment in resident room and in a binder in nursing station. Licensed nurses in-serviced on procedure for CPAP/AVAP therapy and documentation of care and cleaning per | | |

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| F 328 | <p>Continued From page 69</p> <p>the potential for the resident's respiratory condition to worsen and heightened the possibility for increased sleepiness and lethargy during the day. Findings included:</p> <p>Resident #7 was admitted to the facility on 7/3/12 with diagnoses which included unspecified schizophrenia, anxiety and other symptoms involving respiratory system.</p> <p>Resident #7's most recent quarterly MDS assessment, dated 1/19/15, documented the resident was cognitively intact with a BIMS score of 15.</p> <p>The Medication Review Report (recapitulation orders) for March 2015 documented an 8/8/14 order for AVAP with O2 (oxygen) at 3 LPM (liters per minute) one time a day for sleep disorder related to insomnia.</p> <p>Note: AVAP (Average Volume Assured Pressure) is a device which delivers consistent tidal volume for those who require ventilatory support.</p> <p>The resident's care plan for altered respiratory status/difficulty breathing related to sleep apnea, initiated on 5/8/14, documented an intervention to, "Report to Nurse any difficulties [name of resident] has with use of AVAP." An intervention was added on 8/8/14 for, "Oxygen therapy via AVAP HS [hour of sleep] 2 LPM."</p> <p>No documentation was found in the care plan which directed staff to check for proper placement to secure a seal, how often oxygen tubing would be replaced, use of distilled water, or how to care and clean the AVAP device or who to call if the machine needed maintenance.</p> | F 328 | <p>manufacturer recommendation on 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Health information manager or designee will audit CPAP/AVAP process change weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 328 | Continued From page 70 No documentation was found in the MAR/TAR for March 2015 for the AVAP device. On 3/25/15 at 10:15 AM, the resident was interviewed and stated she managed and cleaned the AVAP machine herself. She stated she put the facemask on at night, took it off in the morning and preferred to clean it herself. She stated she had used the machine a long time, knew how to clean it and knew it was done correctly. On 3/25/15 at 4:35 PM, LN #4 stated 3 LPM was the current order and not 2 LPM as listed on the care plan. She stated the resident had some problems with a leak and had received a new mask after a sleep study which was done on 8/27/14. She stated the care plan should document 3 LPM and not 2 LPM. LN #4 stated the care plan should include the proper use, care and cleaning of the VPAP should the resident not be able to put it on or take care of it herself. When shown the facility's Procedure for Continuous Positive Airway Pressure (CPAP) Therapy which listed, "Please refer to the manufacturer's instructions," LN #4 stated, "I would expect to see some instructions and detail." | F 328 | | | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any | F 329 | | | |

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| F 329 | <p>Continued From page 71</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure residents who received psychopharmacological, pain, bowel, and antibiotic medications: *Were adequately monitored; *Received adequate risk and benefit information; *Received adequate gradual dose reductions (GDR); *Did not receive duplicate therapy; *Received physician justification for medications with a drug to drug interaction; and, *Did not receive an excessive dose of antibiotics.</p> | F 329 | <ol style="list-style-type: none"> 1. Resident #1, 3, and 5-9 were reviewed and showed no unanticipated decline or newly emerging or worsening symptoms. Resident #1, 5, and 7 were reviewed for gradual dose reduction with recommendation sent to physician on 4/22/2015. Resident #3 received additional dose of antibiotic, no adverse effect noted, MD notified. 2. All residents who receive psychopharmacological, pain, bowel, and antibiotic medications have the potential to be affected by this practice. 3. On admission, and with new orders, residents will receive adequate risk benefit information for medications with Black Box Warnings. Health information manager will review all medications requiring a stop date to ensure correct transcription. | | |

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| F 329 | <p>Continued From page 72</p> <p>These failures created the potential for harm should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms. This was true for 7 of 10 sampled residents (#s 1, 3, & 5-9). Findings included:</p> <p>1. Resident #5 was admitted to the facility on 3/18/15 with multiple diagnoses including dementia without behavioral disturbance, schizoaffective disorder, psychosis, insomnia, and anxiety.</p> <p>a. The resident's Initial Antipsychotic Medication Assessment, dated 3/18/15, documented, "Aggressive behavior" under the sections: Physical Behavioral Symptoms Directed Toward Others; Verbal Behavioral Symptoms Directed Toward Others; and, Other Behavior Symptoms Not Directed Toward Others.</p> <p>The resident's care plan, dated 3/18/15, documented:</p> <ul style="list-style-type: none"> - A focus of, "[Resident #5] is on antipsychotic medication therapy R/T [related to] Schizophrenia" and interventions of, "Monitor for behavioral symptoms that present a danger to the resident or others" and "Monitor symptoms of mania or psychosis (such as auditory, visual or other hallucinations; delusion)." - A focus of, "[Resident #5] uses anti-anxiety medications R/T anxiety disorder" and interventions of, "Give anti-anxiety medications ordered by health care provider. Monitor/document side effects and effectiveness..." | F 329 | <p>Residents who use antipsychotic drugs will receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue these drugs.</p> <p>Physician will be informed of duplicate therapy, and request for justification of medications with a drug to drug interaction to decrease the potential should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms.</p> <p>Pharmacy will review residents psychopharmacological, pain, bowel, and antibiotic medications with recommendations forwarded to Director of Nursing and Physician for action steps.</p> <p>Target behaviors for PRN psychoactive medications will be added to electronic medical record for documentation.</p> <p>Staff will attempt and nursing staff will document outcome of two non-pharmacological</p> | |

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| F 329 | <p>Continued From page 73</p> <p>In addition to multiple routine medications for anxiety, psychosis and schizoaffective disorder, the resident's March 2015 MAR documented orders for: "Clonazepam tablet .5 MG Give 1 tablet by mouth every 8 hours as needed for anxiety related to Anxiety State." and, "Risperdal tablet 1 MG Give 1 tablet by mouth every 8 hours as needed for schizoaffective disorder."</p> <p>The resident's March 2015 progress notes were reviewed and the progress notes related to the resident's behavior were: 3/18/15 at 1:23 PM, "...no negative behaviors noted this shift;" 3/23/15 at 4:38 PM, "Resident is fidgety with his hands at times. When he is at the dining table he moves his silverware and drinks;" and, 3/24/15 at 11:30 PM, "Late Entry: Noted abrasions on resident's face that were not there this morning. They appear to be from resident's excessive shaving. Resident is becoming increasingly verbally aggressive and has tried to pull electronic razors out of the hands of staff. According to his family, resident will shave nearly the entire day if razors are not removed from room."</p> <p>During the survey, the following observations were made: 3/23/15 -4:25 PM, The resident was in the recliner in his room, watching TV; 3/24/15 -8:30 AM, The resident was in the recliner in his room, watching TV; -8:43 AM, The resident's call light was on and a staff member went into his room and a minute later, they walked down to the Rehabilitation Dining Room together; -9:15 AM, The resident walked, by himself, from</p> | F 329 | <p>interventions offered before administering a PRN medication. Behavior charting will be changed from PRN to every shift.</p> <p>Behavior committee and Medical director were educated on adequate monitoring of medications which require gradual dose reductions, need for adequate risks and benefit information, as well as justification for medications with a drug to drug interaction on 4/1/2015. License nursing in-service on administration and assessment of the effectiveness of one medication before taking another, Stop dates for antibiotic medications to avoid excessive dose administration, Psychoactive medication with behavior documentation, Gradual dose reduction, Review of duplicate therapy, Need for physician justification for medications with a drug to drug interaction and for pain, bowel, and antibiotic monitoring on 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for</p> | |

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| F 329 | <p>Continued From page 74 the dining room to his room; -10:40 AM, The resident was in the recliner in his room, sleeping; -12:40 PM, The resident was in the dining room eating independently; -3:12 PM, The resident was in the recliner in his room watching TV, turned his call light on and requested a piece of candy from the CNA who answered his light; 3/25/16 -9:35 AM, The resident was in the recliner in his room, watching TV; and, -12:50 PM, The resident was in his recliner in his room, eating his lunch;</p> <p>The March 2015 MAR documented the resident received the scheduled medications as ordered. Above the order time, the MAR documented, "Beh" and on the same line for each administration time was documented with a "yes" or a "no". The MAR documented on 3/25/16 at 1:37 PM and 1:38 PM, the resident received PRN Clonazepam and PRN Risperdal and on the "Beh" line was documented with a, "Y" and a, "yes." The progress note associated with the Clonazepam, documented, "...Verbally aggressive, unable to redirect." There was no note associated with the Risperdal administration. Note: Both medications were given within a minute of each other. The progress note did not identify how the resident's behaviors placed the resident or others at risk of harm. There was no documentation of non-pharmacological interventions attempted before the administration of the two medications. It was not clear from the documentation why the resident required both an anti-psychotic and an anti-anxiety medication to be administered at the same time, rather than administer and assess the effectiveness of one medication before using the other.</p> | F 329 | <p>root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit changes to process weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 329 | Continued From page 75 The resident's progress notes dated 3/25/15 at 3:10 PM, documented for both PRN Clonazepam and PRN Risperdal the medications were, "Effective Sleeping." On 3/26/15 at 9:30 AM, the DON was interviewed regarding behavior monitoring. When asked what the 'Beh' stood for, she said it was for the behavior monitors because the facility's new computer system did not allow very many letters in that section. She said the 'yes' or 'no' was if the resident experienced behaviors. When ask how nurses would know what specific behaviors were treated with the medication, she stated it was, "not on the MAR." She said however, the nurses could look at the care plan for the identified behaviors, give the medication and then the system allowed the nurse to make a behavior progress note. When informed of the lack of progress notes for the resident for the antipsychotic medications, she stated nurses did not document, "as often as I would like them to." c. The resident's March 2015 MAR documented orders, dated 3/18/15: "Risperidone [Risperdal] tablet .5 MG Give 1 tablet by mouth two times a day related to Schizoaffective Disorder; Quetiapine Fumarate [Seroquel] tablet 200 MG Give 1 tablet by mouth one time a day related to unspecified psychosis; and, Risperdal tablet 1 MG Give 1 tablet by mouth every 8 hours as needed for schizoaffective disorder." No documentation was found in the medical record where the resident or resident's representative were informed of the risks and | F 329 | | | |

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| F 329 | <p>Continued From page 76</p> <p>benefits for the use of Seroquel and Risperdal, including the risk of death in the elderly. At the time of survey, the resident was 72 years old.</p> <p>From 3/23/15 at 4:25 PM through 3/25/15 at 12:50 PM, the resident was observed to only answer yes and no questions and one word responses.</p> <p>On 3/25/15 at 10:40 AM, the Medical Records informed the surveyor she could not find a black box warning in the medical record and she stated the Social Worker would know more.</p> <p>On 3/25/15 at 10:50 AM, the Social Worker was interviewed and she said she would normally go over the risks and benefits and black box warning when she met with the family. When asked if she had met with the family yet, she stated, "I have not."</p> <p>d. The resident's March 2015 MAR documented an order, dated 3/18/15, for 1 tablet of Trazodone 100 MG to be administered at bedtime for insomnia. The MAR documented the resident had received the medication as ordered. The MAR did not include an area to monitor for hours of sleep for the resident.</p> <p>On 3/26/15 at 9:30 AM, the DON was interviewed regarding the lack of sleep monitors and she stated, "We don't have that monitored." She said since the medication is an anti-depressant, the computer system did not automatically populate an area to track hours of sleep.</p> <p>2. Resident #6 was admitted to the facility on 2/28/14 with multiple diagnoses including dementia with behavioral disturbances and</p> | F 329 | | | |

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| F 329 | <p>Continued From page 77 reactive psychosis.</p> <p>The resident's care plan, dated 3/5/14, included non-pharmalogical interventions related to elopement risks and also documented focus of, "[Resident #6] is on antipsychotic medication therapy R/T dementia w/[ith] behavioral symptoms" and an intervention of, "Monitor for behavioral symptoms that present a danger to the resident or others..."</p> <p>The resident's March 2015 MAR documented orders, dated 9/3/14, "Seroquel tablet (Quetiapine Fumarate) Give 50 mg by mouth at bedtime related to dementia w/ behavioral disturbances dementia with psychotic hallucinations and potential for self-harm."</p> <p>The March 2015 MAR documented the resident received the scheduled medications as ordered. Above the order time, the MAR documented, "beh" and on the same line for each administration time was documented with a "0".</p> <p>The resident's March 2015 progress notes were reviewed and the only Mood/Behavior progress notes on 3/11/15 and 3/19/15, documented, "...resident refused to use O2 [oxygen]" and "Resident attempting to exit building, stating she can hear her children outside calling for her."</p> <p>During the survey, the following observations were made: 3/24/15 -8:35 AM, The resident was in the recliner in her room, watching TV; -9:17 AM, The resident was in the Rehabilitation Dining Room ordering breakfast; -10:55 AM, The resident was in her room counting coins;</p> | F 329 | | |

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| F 329 | <p>Continued From page 78</p> <p>-12:42 PM, The resident was in the Rehabilitation Dining Room eating lunch;</p> <p>-3:07 PM, The resident was in her room putting her doll to sleep in the bed; and,</p> <p>3/25/15 -12:10 PM, The resident was in the Rehabilitation Dining Room waiting for her lunch to be served.</p> <p>On 3/25/15 at 9:50 AM, the DON was interviewed regarding behavior monitoring. When asked what behaviors were being monitored, she stated, "[The MAR] doesn't have specific behavior for that resident." The DON acknowledged the MAR and progress notes were the only places staff would document behaviors.</p> <p>3. Resident #8 was admitted to the facility on 7/18/11 with multiple diagnoses including bipolar disorder, dementia with behavioral disturbances and psychosis.</p> <p>The resident's care plan, dated 11/5/13, documented a focus of, "[Resident #8] is on antipsychotic medication therapy R/T dementia and behavior problems E/B [Exhibited By] physical and verbal behaviors toward staff and refusal of cares" and an intervention of, "Monitor for a significant decline in function and/or substantial difficulty receiving needed care behavioral symptoms that present a danger to the resident or others ..."</p> <p>The resident's March 2015 MAR documented orders, dated 5/2/14, "Zyprexa tablet 5 MG give 1 tablet by mouth in the evening..." for Bipolar Disorder.</p> <p>The March 2015 MAR documented the resident received the scheduled medications as ordered.</p> | F 329 | | | |

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| F 329 | <p>Continued From page 79</p> <p>Above the order time, the MAR documented, "beh" and on the same line for each administration time was documented with a "yes", "no", "x", or "0".</p> <p>The resident's March 2015 progress notes were reviewed and there were no notes found regarding the resident's behavior.</p> <p>During the survey, the following observations were made: 3/25/15 -4:48 PM, The resident was asleep in bed; -5:10 PM, The resident was in the main dining room with water, juice, and a supplement in front of him; and, -5:47 PM, The resident was in the main dining room being assisted by a CNA, with his dinner meal</p> <p>On 3/26/15 at 10:10 AM, the DON was interviewed regarding behavior monitors. She reviewed the MAR and the progress notes and was asked if she could find what behavior was monitored associated with the medication and she stated, "There's nothing there for the Zyprexa."</p> <p>4. Resident #3 was admitted to the facility in 2013 and readmitted 12/1/13, 5/16/14, and 2/7/15 with multiple diagnoses including contracture of lower leg joint, generalized pain, and unspecified hemiplegia affecting non-dominant side.</p> <p>The resident's 3/3/15 telephone order documented, "Levaquin [antibiotic] Tablet 500 MG [mg for milligrams] (levofloxacin) Give 1 tablet by mouth one time a day for Congestion; Cough x [times] 7 days."</p> | F 329 | | | |

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| F 329 | <p>Continued From page 80</p> <p>The resident's March 2015 MAR documented that Levaquin was administered daily for 9 days, from 3/4 - 3/11 and again on 3/16, rather than 7 days as ordered. The MAR contained "Chart Codes / Follow Up Codes" which included "4=Drug not available" and "8=Other / See Nurse Notes". An "8 [see nurses notes]" was documented on 3/12 and 3/13 and a "4 [drug not available]" was documented on 3/14 and 3/15.</p> <p>The Progress Notes included the following documentation: * 3/12/15 - "Levaquin...7 day course completed." * 3/13/15 - "Levaquin...Course is finished." * 3/14/15 and 3/15/15 - "Levaquin...Not delivered from pharmacy." * 3/16/15 - There was no documentation about the Levaquin on this day.</p> <p>On 3/27/15 at 4:45 p.m., LN #8 was asked about the extra days the antibiotic was administered to Resident #3. The LN acknowledged extra doses of the antibiotic were documented as administered on 3/11 and 3/16. She stated, "All I can tell is the nurse put in the wrong end date." When asked if a different order extended the length of time for the antibiotic, the LN indicated there were no orders which extended the number of days for the antibiotic. The LN was asked if nurses who administer medications are supposed to read the order. She stated, "They should." The LN was asked if the resident's physician was notified of the error. She stated, "I don't think it was discovered until today."</p> <p>On 3/27/15 at 5:30 pm, the Administrator, DON, and Social Worker were informed of the excessive amount of antibiotic medication. The facility did not provide any other information about</p> | F 329 | | | |

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| F 329 | <p>Continued From page 81 the issue.</p> <p>5. Resident # 9 was admitted to the facility 12/8/12 with multiple diagnoses including depressive disorder, psychosis, anxiety, and dementia.</p> <p>On 9/24/14, a GDR (gradual dose reduction) meeting was documented. Medications discussed included: *Seroquel 100 mg BID (two times a day) with diagnosis of psychosis *Risperidone 1 mg daily with diagnosis of psychosis *Ativan 0.5 mg PRN (as needed) with diagnosis of anxiety *Celexa 40 mg daily with diagnosis of depression *Namenda XR (extended release) 28mg every day with diagnosis of dementia *Aricept 10 mg every day with diagnosis of dementia</p> <p>The result of this meeting included a discontinuation of Risperidone by the Medical Director. No rationale was listed for this decision. No discussion, changes, or rationales were listed for any other medications.</p> <p>Note: The facility's method of documenting GDR meetings changed to a form called "Behavioral Committee Drug Review" in the following examples.</p> <p>On 12/17/14, another GDR meeting ("Behavioral Committee Drug Review") was documented. Medications discussed were: *Seroquel 100 mg BID (two times a day) with diagnosis of psychosis</p> | F 329 | | | |

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| F 329 | <p>Continued From page 82</p> <p>*Ativan 0.5 mg PRN (as needed) with diagnosis of anxiety *Celexa 40 mg daily with diagnosis of depression *Namenda XR (extended release) 28 mg every day with diagnosis of dementia *Aricept 10 mg every day with diagnosis of dementia</p> <p>Medical Director comment included "resident is stable, dose reductions clinically contraindicated at this time." No other rationale, changes, or discussion were documented.</p> <p>On 1/28/15 a "Behavioral Committee Drug Review" was documented. The same medications as listed above, in the previous meeting on 12/17/14, were discussed. The only suggested change documented included: "consistent HS [hour of sleep] use of Ativan for insomnia-start scheduled HS dose." No other rationale, changes, or discussion were documented.</p> <p>Note: Chart review revealed behavior monitoring on the MAR, with a row for "beh" for "behavior" and either a "yes" or "no" documented if the behavior did/did not occur. The specific behavior observed was not noted on the MAR. Behaviors were connected to progress notes, however, progress notes were inconsistent in regards to the indication of administering medication. Regarding Ativan for sleep, no sleep pattern monitoring or non-pharmacological interventions were documented in progress notes for the month of March. In addition, causitive factors for insomnia were not assessed on the Behavioral Committee Drug Review from 1/28/15.</p> <p>On 3/25/15 at 5:30 p.m., Resident #9 was</p> | F 329 | | | |

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| F 329 | <p>Continued From page 83</p> <p>observed in the dining room. She was sitting in her wheelchair, sliding down so her head was on the back rest of the wheelchair. She had her eyes closed and never opened them for the 15 minutes surveyor spoke with the resident's son. Son fed her, only eating when food was brought to her mouth.</p> <p>3/27/15 at 9:30 a.m., the Director of Social Services was interviewed regarding GDR meetings. When asked how information was gathered for a GDR meeting, besides the "yes" and "no" boxes on the MAR, she said, "we look to see if there is a note connected to it, mood charting notes, and CNA [certified nursing assistant] notes from the plan of care." When asked what the facility does if there are no progress notes to prepare for the GDR, and how they decide to keep the residents on medications, she said "I bring forward what I have, and if there's nothing he [the medical director] uses his assessment and knowledge of the patient to make a decision."</p> <p>On 3/27/15 at 12:15 p.m., the Medical Director was also interviewed regarding GDRs. He stated the behavioral monitoring information came from the staff themselves, "they have a good idea of what is going on." He stated they had paperwork each month that they filled out about behaviors, and this is where he got his information for the GDR. When asked if he was aware that behavior monitoring was inaccurate and incomplete, he stated he had "never witnessed inaccurate information." He stated he relied on the facility staff for behavior monitoring information for these GDR meetings.</p> <p>Note: The Director of Social Work stated if there</p> | F 329 | | | |

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| F 329 | <p>Continued From page 84</p> <p>is not enough information to bring to a GDR meeting, the Medical Director uses his assessment skills to make a GDR decision. The Medical Director then stated he relies on the facility to supply the assessments on their paperwork to make his decision. These statements contradict in regards to where the information is coming from for these GDR meetings.</p> <p>On 3/27/15 at 5:30 p.m., the Administrator, DON, Director of Social Services, and LN#8 were notified of the issue.</p> <p>6. Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>The annual MDS assessment, dated 10/10/14, and quarterly MDS assessment, dated 1/8/15, documented the resident was severely cognitively impaired with a BIMS score of 3.</p> <p>Record review of the resident's Medication Review Report (MRR) for March 2015, documented the resident received duplicate therapy for pain, depression and constipation.</p> <p>a. The resident's pain medication orders documented: *Tylenol Tablet, give 650 mg (milligrams) by mouth as needed for pain, ordered 8/19/13; *Fentanyl 25 mcg (micrograms) transdermally one time a day every 3 day(s) for generalized pain, ordered 10/13/13; *Norco 5-325 mg, give 1 tablet by mouth three times a day for pain-moderate related to generalized pain, physician to review effectiveness in 2 weeks, ordered 2/25/15; *Norco 5-325 mg, give 1 tablet by mouth as</p> | F 329 | | | |

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| F 329 | <p>Continued From page 85</p> <p>needed QID for generalized pain, ordered 2/25/15; and,</p> <p>*Norco 5-325 mg, give 2 tablets by mouth as needed QID for generalized pain, ordered 2/25/15.</p> <p>b. The resident's depression medication orders documented:</p> <p>*Lexapro 20 mg, give 1 tablet by mouth in the morning for depression, ordered 1/15/13; and,</p> <p>*Remeron 45 mg, give 1 tablet by mouth at bedtime for depression, ordered 12/17/14.</p> <p>c. The resident's constipation medication orders documented:</p> <p>*Dulcolax Suppository (Bisacodyl), insert 10 mg rectally once daily as need for constipation, ordered 7/10/13;</p> <p>*Enema Disposable Enema (Sodium Phosphates), insert 1 unit rectally once daily as needed for constipation, ordered 7/10/13;</p> <p>*Milk of Magnesia Suspension 1200 mg/15 mg, give 30 ml by mouth as needed for constipation once daily, ordered 8/19/13;</p> <p>*Colace Syrup (Docusate Sodium), give 100 mg by mouth one time a day for constipation, ordered 8/15/14; and,</p> <p>*Bisacodyl Suppository, insert 1 dose rectally one time a day every 3 days for constipation; ordered 8/19/14.</p> <p>d. Similar results regarding lack of behavior monitoring were found for Resident #1.</p> <p>On 3/27/15 at 3:10 PM, the LSW was asked if the facility had documentation of physician justification for the use of duplicate therapy for pain, depression and constipation. The LSW stated she would check for physician justification.</p> | F 329 | | | |

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| F 329 | <p>Continued From page 86</p> <p>When asked when the last gradual dose reduction (GDR) had been done for Lexapro, the LSW provided a copy of the Behavioral Committee Drug Review (BCDR), dated 2/25/15, and a copy of the GDR progress note, dated 2/25/15, along with additional GDR progress notes. The 2/25/15 BCDR did not document GDR considerations. The 2/25/15 progress note, by the LSW, documented only the resident's medication regimen was stable. The 12/9/14 GDR progress note, by the LSW, documented, "MD stated that res[ident] is clinically stable, he suggested to resume Remeron 30 mg Q [every]PM due to weight going from 144 to 133." No documentation was found in the BCDR or the GDR progress notes which indicated the risks and benefits had been evaluated and a GDR for Lexapro was contraindicated.</p> <p>7. Resident #7 was admitted to the facility on 7/3/12 with diagnoses which included unspecified schizophrenia, anxiety and other symptoms involving respiratory system.</p> <p>Resident #7's most recent quarterly MDS assessment, dated 1/19/15, documented the resident was cognitively intact with a BIMS score of 15.</p> <p>Record review of the resident's MRR for March 2015, documented the resident received duplicate therapy for pain, anti-anxiety medications and constipation.</p> <p>a. The resident's pain medication orders documented: *Acetaminophen Tablet, give 500 mg by mouth every 6 hours as needed temp related to generalized pain, ordered 3/8/13;</p> | F 329 | | | |

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| F 329 | <p>Continued From page 87</p> <p>*Biofreeze Gel 4 %, apply to areas of pain topically every 2 hours as need for generalized pain, ordered 9/30/13;</p> <p>*Hydrocodone-Acetaminophen Tablet 5-325 mg, give 1 tablet by mouth every 6 hours as need for generalized pain, ordered 11/7/14;</p> <p>*Robaxin 750 mg by mouth three times a day for muscle spasms as well as PRN, ordered 3/5/15;</p> <p>*Robaxin 750 mg by mouth as needed QID (four times daily) for mild to moderate pain related to generalized pain, ordered 3/23/15;</p> <p>*Tramadol HCl 50 mg by mouth as needed for generalized pain and every HS (hour of sleep) PRN, ordered 10/2/14;</p> <p>*Tramadol HCl 50 mg, give one tablet by mouth as needed for pain prior to therapy, can include restorative PRN, ordered 10/2/14; and,</p> <p>*Tramadol HCl 50 mg, give 1-2 tablets by mouth every 6 hours as needed for mild to moderate pain, ordered 1/9/15.</p> <p>Note: It could not be determined how often the 3/5/15 Robaxin 750 mg order for pain could be given on a PRN basis, until 18 days later when the 3/23/15 order specified QID.</p> <p>b. The resident's anti-anxiety medication orders documented: *Clonazepam Tablet Dispersible 0.25 mg, give 1 tablet by mouth two times a day for anxiety, ordered 8/1/14; and, *Ativan Tablet, give 0.5 mg by mouth every 8 hours as needed for anxiety, ordered 10/22/14.</p> <p>c. The resident's constipation medication orders documented: *MiraLax Powder, give 17 grams by mouth as needed for constipation, ordered 4/6/13; *Dulcolax Tablet, give 5 mg by mouth as needed for constipation, ordered 6/24/13;</p> | F 329 | | |

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| F 329 | <p>Continued From page 88</p> <p>*Senna 8.6-50 mg, give 1 tablet by mouth one time a day for constipation; ordered 9/30/13; *Milk of Magnesia Suspension 1200 mg/15 ml, give 30 ml by mouth as needed for constipation, ordered 8/5/13; *Colace Capsule, give 100 mg by mouth two times a day for constipation, ordered 9/30/13; *Bisacodyl Suppository 10 mg, insert 1 suppository rectally as needed for constipation every day, ordered 5/6/14; *Senna tablet, give 2 tablets by mouth one time a day for constipation, ordered 1/9/15; and, *MiraLax Powder, give 17 grams by mouth two times a day for constipation, ordered 1/9/15.</p> <p>d. Record review of the resident's MRR for March 2015, documented a 7/3/12 order for Prozac 40 mg by mouth one time daily for depression. The resident's medical record did not contain documentation of a GDR for 2014. There was documentation of a 2/25/15 BCDR in which the physician listed Prozac for the treatment of depression and was "clinically stable." However, the physician did not document a GDR had been attempted or that it was clinically contraindicated. Additionally, the MRR for March 2015 documented the resident took Tramadol for the diagnosis of pain, as mentioned above.</p> <p>The 2014 Nursing Drug Handbook, 34th Edition, by Wolters, Kluwer/Lippincott Williams & Wilkins, page 622, listed in the Drug-drug Interactions section for Prozac an interaction with Tramadol in bold black type. It documented, "May increase the risk of serotonin syndrome. Avoid combinations of drugs that increase the availability of serotonin in the CNS (central nervous system); monitor patient closely if used together." A review of the resident's medical record did not contain</p> | F 329 | | | |

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| F 329 | <p>Continued From page 89</p> <p>documentation the resident was being monitored closely for drug-drug interactions. The medical record did not contain physician justification for the use of Tramadol with Prozac.</p> <p>e. Federal Guidance at F-329 in considerations specific to antipsychotics used to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia...), the GDR may be considered contraindicated, if:</p> <p>*The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating any underlying psychiatric disorder; or</p> <p>*The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>Record review of the resident's MRR for March 2015, documented a 9/30/13 order for Abilify 30 mg by mouth one time a day for schizophrenia. However, a GDR for Abilify, an antipsychotic medication, was not found in the resident's medical record. Additionally, the MRR documented a 8/1/14 order for Clonazepam 0.25mg daily for anxiety. However, a GDR was not found in the resident's medical record. A 2/25/15 BCDR documented the resident took Abilify 30 mg daily for the treatment of schizophrenia, Clonazepam 0.25 BID for the treatment of</p> | F 329 | | | |

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| F 329 | Continued From page 90 anxiety, Lorazepam 0.5 mg every 8 hours PRN for the treatment of anxiety and Prozac 40 mg for the treatment of depression. The physician documented the resident was clinically stable. There was no documentation in the BCDR a GDR had been attempted or was contraindicated for any of the medications listed. A 2/25/15 progress note by the LSW documented, "MD stated that res[ident] is clinically stable and suggests no changes at this time." On 3/27/15 at 2:30 PM, the LSW was asked if the facility had documentation of physician justification for the use of duplicate therapy for pain, constipation, or anti-anxiety and, in particular, the use of a short acting benzodiazepine with a long acting benzodiazepine. The LSW stated she would check for physician justification. When asked about GDR's for Abilify, Prozac, and Clonazepam, the LSW produced the 2/25/15 showing the physician commented, "Clinically stable." When asked if there was physician justification about the drug-drug interaction between Prozac and Tramadol and monitoring for its use, the LSW stated, "Not that I'm aware of." On 3/27/15 at 4:00 PM, the LSW gave the surveyor a typed sheet of paper which documented, "Unable to find physician justification for duplicate therapies for [Resident #1] and [Resident #7]." On 3/27/15 at 5:30 PM, the Administrator and DON were made aware of the aforementioned concerns. No further information was provided by the facility. | F 329 | | | |
| F 332 | 483.25(m)(1) FREE OF MEDICATION ERROR | F 332 | | | |

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| F 332 SS=D | <p>Continued From page 91 RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater. This was true for 2 of 26 observed medication passes (7.69%) and affected Residents #14 & #16. The failure created the potential for residents to receive less than optimum benefit from their prescribed medications. Findings include:</p> <p>1. CMS letter 13-02-NH refers to administration of medications via feeding tube (including PEG tubes [percutaneous endoscopic gastrostomy]) and documented, "The facility, in consultation with the pharmacist, must provide procedures for the accurate administration of all medications. The procedures must reflect current standards of practice, including but not limited to ... flushing the feeding tube before, between, and after drug administration ... failure to flush before and in between each medication administration is considered a single medication error ..."</p> <p>Resident #16's Recapitulation Orders for March 2015 included: "Baclofen 20 mg (milligrams), 1 tab (tablet) 4x [times per] day per tube feeding," and "155 cc (cubic centimeters) free H2O (water) flush q4h (every four hours) for PEG tube."</p> <p>On 3/25/15 at 12:10 p.m., LN #3 poured 155 cc of</p> | F 332 | <p>1. Resident #14 diabetic management orders updated to include hypo/hyperglycemic protocol on 3/27/15.</p> <p>Resident #16 Orders for enteral medications have been updated to include "flush tube with sterile water before and after administration."</p> <p>2. Residents with feeding tubes or diabetes have the potential to be affected by this practice.</p> <p>3. Licensed nurses will change insulin administration time for AC/HS to the start of meal times, clarify admission diabetic management orders to include Hypoglycemic Incident Protocol and physician recommendation for hyperglycemia.</p> <p>Licensed nurses will update enteral medication orders to document "flush tube with sterile water before and after each medication."</p> <p>4. Monitoring: results of audits will be taken to QAA committee for</p> | | |

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| F 332 | <p>Continued From page 92</p> <p>warm sink water into a cup, added a 20 mg baclofen tablet to the water, and stirred until the medication dissolved. The LN then administered this solution into Resident #16's PEG tube. The LN did not flush the PEG tube before or after the dissolved medication was administered to the resident. When asked if the Baclofen was added to the flush water, LN #3 stated, "Yes."</p> <p>On 3/26/15 at 6:10 p.m., the administrator, DON, and Director of Social Services were notified of the issue. No further information on the issue was provided.</p> <p>2. Resident #14 was admitted to the facility on 10/3/14 with multiple diagnoses including diabetes mellitus.</p> <p>Resident #14's recapitulation of physician orders for March 2015 included: *Humalog Solution inject as per sliding scale: 0-150=0; 151-200=2 units 201-250=4 units 251-300=6 units 301-400=8 units 401+=10 units, subcutaneously before meals and at bedtime</p> <p>On 3/24/15 at 3:17 p.m., LN #4 was observed administering Humalog insulin to resident #14. This administration was approximately 1 hour and 45 minutes before the evening meal was scheduled to start. The Nursing 2015 Drug Handbook recommended administering Humalog 5 to 10 minutes before the start of a meal. Humalog, a rapid-acting insulin, works to lower glucose levels in the blood within 30 minutes of administration.</p> | F 332 | <p>root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit process change weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 332 | Continued From page 93 | F 332 | | |
| F 333 SS=D | <p>Refer to F333 Significant Medication Error, for details regarding this deficient practice.</p> <p>On 3/26/15 at 6:10 p.m., the Administrator, DON, and Director of Social Services were notified of the medication error rate issue. The facility did not provide further information on the issue.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure there were no significant medication errors. This was true for 1 of 11 residents (Resident #14) during medication pass observations when insulin was given 1 hour and 45 minutes before ordered for the evening meal. The failure created the potential for resident #14 to have a hypoglycemic (blood glucose [BG] less than 70 mg/dL [milligrams per deciliter] or hyperglycemic (BG more than 110 mg/dL) event. Findings included:</p> <p>Resident #14's recapitulation of physician orders for March 2015 included: *Humalog Solution inject as per sliding scale: 0-150=0; 151-200=2 units 201-250=4 units 251-300=6 units 301-400=8 units</p> | F 333 | <ol style="list-style-type: none"> 1. Resident #14 Diabetic management orders updated for the before meal (AC) time of blood glucose check, insulin sliding scale administration, and electronic medication administration record documentation at the actual start time of meals on 3/27/15. 2. Residents with physician orders for insulin have the potential to be affected by this practice. 3. Licensed nursing staff will contact physician upon admission of a resident with diabetes to clarify individualized parameters for hyperglycemia and hypoglycemia. Insulin administration times will be changed from the preset before meal (AC) to the actual start times of meals. | |

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| F 333 | <p>Continued From page 94</p> <p>401±10 units, subcutaneously before meals and at bedtime</p> <p>The Nursing 2015 Drug Handbook recommended administering Humalog 5 to 10 minutes before the start of a meal. Humalog, a rapid-acting insulin, lowers glucose levels in the blood within 30 minutes of administration according to the Handbook.</p> <p>On 3/24/15 at 3:07 p.m., LN #4 stated she had just finished checking Resident #14's BG just before surveyors arrived. At 3:17 p.m. LN #4 entered resident #14's room to administer 2 units of Humalog insulin for the evening meal (for a BG of 173), approximately 1 hour and 45 minutes before the evening meal was scheduled to start. When asked about meal times in relation to insulin administration, she said, "She had lunch, but just had a yogurt so its okay to give the insulin. If it was 8-10 units then I would worry but it's only 2 units." Note: Meal times for the facility were lunch from 12:00-1:00 p.m. and dinner from 5:00-6:00 p.m.</p> <p>On 3/26/15 at 2:00 p.m., during interview with the DON, she was asked if there were any policy and procedure guidelines for the timeframe BG checks were to be done and when sliding scale insulin should be given. She stated, "Usually an hour window before or after established time." The DON, when asked if she perceived a problem with insulin being given almost 2 hours before a meal, stated, "Yeah, there's potential for a problem."</p> <p>On 3/26/15 at 6:10 p.m., the Administrator, DON, and Director of Social Services were notified of the issue. No further information on the issue</p> | F 333 | <p>Nursing will check blood glucose and administer insulin in a private location just prior to the resident eating. Nursing will ensure diabetic residents receive their meals within 30 minutes of insulin administration.</p> <p>Licensed nurses in-serviced on procedure changes related to diabetes management to obtain hypo/hyperglycemic parameters based on physician orders and insulin administration time was completed on 4/9/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Health information manager or designee will audit new diabetic management orders for hypo/hyperglycemic parameters and administration time changes weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 333 | Continued From page 95 was provided by the facility. | F 333 | | |
| F 353 SS=E | <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the Resident Group Interview, facility call light audits, observations, facility policy and procedure review, record review, and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide the needs and well-being of all residents. This affected 2 of 10 sampled residents (#s 3 & 8), one random resident (#22), 8 of 11 residents who attended the group interview, and had the</p> | F 353 | <ol style="list-style-type: none"> 1. Resident's #3, 8, and 22 call lights will be answered to ensure residents needs and well-being will be met. 2. All residents have the potential to be affected by this practice. 3. Nursing staff will ensure call lights are answered in a timely manner to ensure care needs are addressed by anticipating resident preferences to get up/lay down. <p>Consistent assignment nursing assistant routines were re-evaluated to allow for anticipation of resident care needs related to two staff assist.</p> <p>Nursing staff in-serviced to care plan resident preferences and anticipate daily routines requiring two staff assist on 4/30/15.</p> <ol style="list-style-type: none"> 4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to | |

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| F 353 | <p>Continued From page 96</p> <p>potential to affect all other residents who lived in the facility. This failure created the potential for psychosocial and physical harm to the residents in the facility if call lights were not answered in a timely manner and care needs were not addressed. Findings included:</p> <p>Documentation:</p> <p>1. On 3/26/15 at 3:35 PM, the facility's undated Answering Call Lights policy was provided. It documented: "...If upon answering the call light, the staff member is unable to assist that resident and ensure that their needs have been met, the staff member will leave the call light on until that resident's needs have been met by the staff member, who answered the light, or another staff member or both."</p> <p>2. On 3/26/15 a call light audit from 1/1/15 to 3/25/15 for Resident #3 was requested and reviewed. Call light wait times more than 15 minutes were documented 27 times, and ranged from 15 minutes and 7 seconds to 58 minutes and 1 second.</p> <p>3. On 3/26/15 a call light audit from 1/1/15 to 3/25/15 for Resident #8 was requested and reviewed. Call light wait times more than 15 minutes were documented 5 times, and ranged from 15 minutes and 18 seconds to 36 minutes and 58 seconds.</p> <p>4. On 3/26/15 a call light audit from 1/1/15 to 3/25/15 for Resident #22 was requested and reviewed. Call light wait times more than 15 minutes were documented 39 times, and ranged from 15 minutes to 45 minutes and 28 seconds.</p> | F 353 | <p>sustain compliance.</p> <p>Administrator or designee will audit care plan congruent with resident preference for acceptable call light response time weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 353 | Continued From page 97 Resident Group Interview: On 3/24/15 at 1:00 PM, during the Resident Group Interview, the group complained about lack of staff in the 100 hallway and slow call light response times. Seven out of 11 residents said they regularly waited 15 minutes or longer before their call lights were answered. Eight out of 11 residents said that on a regular basis after their call lights were answered, staff would turn off the light, tell the resident they would be back, leave the room, and not come back for 10 to 15 minutes or more. One resident stated she would even turn the call light back on before the CNA would leave the room, because she knew if she did not, then she would not get her needs met in a timely manner. Staff Interviews: 1. On 3/25/15 at 7:15 AM, CNA #5 stated, "During the weeks we [have enough staff], but during the weekends we don't [have enough staff]." 2. On 3/25/15 at 7:17 AM, CNA #9 stated staffing varied depending on the day of the week at, "Sometimes they only staff the front hallway [100 hallway] with three CNAs." 3. On 3/25/15 at 4:50 PM, CNA #10 stated the facility had enough staff, "sometimes, it depends on the day." She said the 2:00 to 10:00 PM shift normally only had three CNAs for the entire 100 hallway, which included three residents on the 200 hallway. 4. On 3/25/15 at 5:30 PM, CNA #6 was interviewed and asked about adequate staffing. | F 353 | | | |

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| F 353 | <p>Continued From page 98</p> <p>She stated, "Sometimes we are short staffed on the weekends."</p> <p>5. On 3/25/15 at 5:43 PM, CNA #11 stated normally there were only three CNAs for the 100 hallway, but when there were four CNAs, like at the time of the interview, the work went more smoothly. She stated, "with three CNAs, we struggle."</p> <p>6. On 3/26/15 at 3:35 PM, the DON was interviewed with CNA #12 present, regarding call lights and staffing issues. When informed of the group interview concerns over call light wait times and what a specific resident had said, she stated, "If [the resident] perceives it as too long then it's too long." She said if a resident had concerns over call light times, then she would pull the call light times and audit them to see if there were any trends and then adjust staffing as needed. She also said the work load is reviewed each day to make sure they have enough staff and nurses are expected to also answer call lights. When asked if nurses were to answer call lights during the medication pass, she said they were. When informed of the resident concerns regarding call lights being turned off and then helped later, she said this should no longer be an issue since they implemented a new call light policy a few months back. The DON then provided an undated call light answer policy which was given to the staff. When asked about staffing levels on the 100 hallway, especially during the 2:00 to 10:00 PM shift, CNA #12 said there were usually three to four CNAs during that shift.</p> <p>Note: The 100 hallway from resident room 101 to resident room 139 was observed to be over 88 yards long or 12 yards short of a football field. Also, the facility provided a list of 13 residents</p> | F 353 | | | |

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| F 353 | Continued From page 99 who required two person assistance and 11 of those residents resided on the 100 hallway. Other deficiencies cited: Refer to F 241 regarding staff checking a resident's BG while on the toilet. Refer to F 309 regarding lack of effective monitoring for residents with diabetes. Refer to F 323 regarding lack of supervision for residents who wandered. Refer to F 325 and F 327 regarding lack of assistance for eating and drinking. Refer to F329 regarding lack of behavior monitoring, duplicate drug therapy and excessive medication dosages. Refer to F 332 and F 333 regarding early insulin given to a resident. Refer to F 441 regarding lack of handwashing by staff. On 3/27/15 at 5:30 PM, the Administrator, DON, and Social Worker were informed of the staffing issues. No further information was provided by the facility. | F 353 | | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). | F 356 | | | |

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| F 356 | <p>Continued From page 100</p> <ul style="list-style-type: none"> - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to post Nurse Staffing Information in an easy to find location readily accessible to residents and visitors. This had the potential to affect 10 of 10 sample residents (#s 1-10), all others residents living in the facility, and visitors who came to the facility. Findings included:</p> <p>Every day from 3/23/15 to 3/27/15, the Nurse Staffing Information was observed posted sideways in a wall pocket directly under a sign labeled "Business Office." The Nurse Staffing Information was difficult to locate because business office information or paperwork, rather than staffing information, could be expected to be kept in the wall pocket under the "Business</p> | F 356 | <ol style="list-style-type: none"> 1. Nurse Staffing Information pocket folder was labeled to indicate what the information is, changed to an upright orientation, and moved to an easy to find location outside the nurse office and readily accessible to residents and visitors. 2. All residents have the potential to be affected by this practice. 3. Nursing staff were in-serviced to post daily staffing information in the new location on 4/30/15. 4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Office manager or designee will audit weekly X 4, monthly X 2, and quarterly X 3. 5. Compliance on or before May 30, 2015. | 5/30/15 |

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| F 356 | Continued From page 101 Office" sign. In addition, the Nurse Staffing Information was on regular size paper (8 1/2 by 11 inches) turned sideways and there were no other labels to indicate what the information was. On 3/26/15 at 6:00 pm, the Administrator was informed of the issue. The Administrator said the location was prominent. However, he did not comment when informed that having the information in the wall pocket under the "Business Office" sign was misleading which made it was difficult to locate the staffing information. The Administrator said he would move the Nurse Staffing Information to a more visible location as soon as possible. | F 356 | | | |
| F 369 SS=D | 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure special eating equipment was provided and failed to care plan the use of adaptive equipment. This was true for 2 of 7 residents (#7 & 19) sampled for adaptive equipment. This deficient practice had the potential to cause more than minimal harm should residents experience a compromised nutrition status. Findings included: 1. Resident #7 was admitted to the facility on 7/3/12 with multiple diagnoses including abnormal involuntary movement. | F 369 | 1. Resident #7 Care plan updated for use of maroon spoon per speech therapy recommendation and dietary preference card on 4/9/15. Resident #19 weighted utensils provided with meal trays. 2. Residents with need for adaptive equipment have the potential to be affected by this practice. 3. Dietary assistant orientation to include use of adaptive | | |

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| F 369 | <p>Continued From page 102</p> <p>Resident #7's most recent quarterly MDS assessment, dated 1/19/15, documented the resident was cognitively intact with a BIMS score of 15 and required setup help for eating.</p> <p>Record review of the resident's care plan for the focused problems of nutrition, initiated 10/28/13, customized dining services, initiated 2/10/14, and ADL performance, initiated 10/29/13, did not contain documentation the resident required a Maroon Spoon.</p> <p>On 3/25/14 at 12:45 PM, the resident was observed eating independently with a regular fork, knife and spoon in the Idaho Dining Room. The resident's dietary preference card documented in the middle of the page under Adaptive Equipment: "Maroon Spoon" (Maroon Spoons are specialty spoons with a shallow, narrow bowl that facilitates good lip closure, promotes oral desensitization, as well as decreased tongue thrust).</p> <p>Resident #7 was asked if she had a Maroon Spoon and the resident stated she did not. DA #18 was shown the resident's dietary preference card and asked if she had given the resident the Maroon Spoon. DA #18 stated she had not seen the Maroon Spoon on the preference card.</p> <p>On 3/25/15 at 12:55 PM, the DDS stated the Maroon Spoon should have been set up on the table.</p> <p>2. Resident #19 was admitted to the facility 8/11/10 with multiple diagnoses including abnormal involuntary movement.</p> <p>Record review of the resident's care plan for the</p> | F 369 | <p>equipment, transferring adaptive devices to room tray as needed, and honoring resident preferences as indicated on dietary preference card.</p> <p>Dietary staff were in-serviced on changes to process on 4/25/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit care plans and dietary preference cards weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 | |

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| F 369 | Continued From page 103 focused problems of nutrition, initiated 11/5/13, and ADL performance, initiated 11/13/13, did not contain documentation the resident required weighted utensils. On 3/25/15 at 1:10 PM, CNA #17 was observed to deliver a hall lunch tray to Resident #19 who was sitting in a lounge chair in her room. The tray contained a regular fork, knife, and spoon. The resident's dietary preference card documented in the middle of the page under Adaptive Equipment: "Weighted utensils." On 3/25/15 at 1:15 PM, CNA #17 stated, "Sometimes I don't check the preference card and it is something I need to work on." On 3/26/15 at 12:05 PM, the DDS stated, "It is the responsibility of the DA to make sure the adaptive equipment utensils are on the trays. For [Resident #19], she usually eats in her room and the dietary aide should have made sure the resident's lunch tray had weighted utensils." | F 369 | | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | | |

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| F 371 | Continued From page 104 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was prepared in a sanitary environment. This created the potential for cross-contamination of food and exposed 10 of 10 sample residents (#s 1-10) and all other residents who ate meals prepared in the facility's kitchen to potential sources of pathogens. Findings included: On 3/23/15 at 1:07 PM, during the initial tour of the kitchen with the Director of Dietary Services (DDS) in attendance, an accumulation of dust was observed on the entire length of a 7-8 foot long sprinkler tubing located directly above the grill. An accumulation of dust was also observed on the vent located directly above the grill. The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "... (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." On 3/27/15 at 1:15 PM, the DDS stated, "I will get the sprinkler tubing and vent cleaned, there shouldn't be dust up there." On 3/26/15 at 6:10 PM, the Administrator and DON were informed of the kitchen cleanliness concerns. No further information was provided by the facility. | F 371 | <ol style="list-style-type: none"> 1. Long sprinkler tubing and vent above the grill were cleaned on 3/27/15. 2. All residents have the potential to be affected by this practice. 3. Dietary cleaning schedules implemented for sprinkler tubing daily and hood vents biweekly. Equipment has been placed on maintenance cleaning TELS program. Dietary and maintenance staff re-educated on cleaning schedule and addition to TELS program on 4/25/15. 4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Administrator or designee will audit cleaning schedule weekly X 4, monthly X 2, and quarterly X 3. 5. Compliance on or before May 30, 2015. | 5/30/15 |

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| F 431 SS=D | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record</p> | F 431 | <ol style="list-style-type: none"> 1. Resident #17's Insulin orders were immediately checked by the licensed nurse to verify the dose given was accurate. Pharmacy was notified of incorrect label. Per pharmacy direction, a labeling sticker was placed to indicate "directions changed refer to chart." Nurse faxed a copy of verified current order for refill on 3/26/15. 2. All residents have the potential to be affected by this practice. 3. Licensed nurses will verify current physician orders are the same as pharmacy labels with each medication administration. If the original label does not match the order, per pharmacy direction a labeling sticker will be placed on the label to indicate "directions changed refer to chart" and pharmacy will be notified and sent the correct order. <p>Licensed nurse in-serviced to above changes to procedure completed on 4/9/15.</p> | |

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| F 431 | Continued From page 106 review, it was determined the facility failed to ensure medications were labeled in accordance with physician orders. This was true for 1 of 26 medications during medication pass observations. The failure created the potential for Resident #17 the resident to receive the wrong dose of Humalog insulin which could have resulted in a hypoglycemic (Blood glucose [BG] less than 70) or hyperglycemic (BG more than 110) event. Findings include: On 3/26/2015 at 11:10 a.m., LN #1 was observed administering 4 units of Humalog insulin per sliding scale, for a blood sugar level of 221 mg/dL (milligrams/deciliter) to Resident #17 per physician order, however, the label on the Humalog bottle read: "Inject 8 units subcutaneously three times a day before meals." Immediately after the observation, the LN was asked about the difference between the label on the Humalog bottle and the dose administered. The LN stated, "It's different," then looked up physician orders on the computer. She was unable to find any other Humalog orders other than the order started on 9/30/13. | F 431 | 4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit medication labeled in accordance with physician orders weekly X 4, monthly X 2, and quarterly X 3. 5. Compliance on or before May 30, 2015. | 5/30/15 | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission | F 441 | | | |

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| F 441 | <p>Continued From page 107 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, it was determined the facility failed to ensure staff consistently implemented infection control measures. This</p> | F 441 | <p>1. Resident #23's cloth privacy bag for urinary drain bag was immediately adjusted up off of the floor by licensed nurse.</p> <p>Resident #5, 12, and 13 monitored and have had no adverse effects noted from staff not performing hand hygiene.</p> <p>Resident #7, 15, and 19 CNA used hand sanitizer after lack of hand hygiene was addressed, no latent adverse effects noted.</p> <p>Resident #20, 18, and 15 no adverse effects noted from not maintaining infection control during medication pass. Licensed staff re-educated on hand hygiene between medications and eye drops.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. Catheter privacy bags will be hung correctly to keep from touching the floor.</p> <p>Staff will follow Procedure for Hand Hygiene and gloving.</p> | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 | | |
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| F 441 | <p>Continued From page 108</p> <p>was true for 2 of 10 sample residents (#s 5 and 7) and 7 random residents (#s 12, 13, 15, 18, 19, 20, and 23) when a urinary privacy bag was in contact with the floor, a barrier was not utilized under a glucometer on un-sanitized surfaces, and when hand hygiene was not performed after direct contact with and between residents and/or after glove removal. Additionally, the facility failed to ensure its policy and procedures included cleaning and disinfecting of scissors that were shared among residents. This was true for 10 of 10 (#s 1-10) sampled residents and any residents who resided in the facility. These failures created the potential for infections to develop and spread from cross contamination. Findings included:</p> <p>1. On 3/24/15 at 9:10 a.m., Resident #23 was observed in the TV Lounge area in his w/c with his urinary drainage bag in a cloth privacy bag under the w/c and in direct contact with the floor. Moments later, the resident's cloth privacy bag drug on the floor when LN #4 wheeled the resident to his room.</p> <p>LN #4 was interviewed immediately after the observation. When asked about the resident's privacy bag in contact with floor, the LN looked at the privacy bag and stated, "Yes it is! It needs to be adjusted up." The LN adjusted the bag off the floor. When asked what the privacy bag was made of, LN #4 stated, "Cloth."</p> <p>On 3/26/15 at 6:00 pm, the Administrator, DON, and Social Worker were informed of the infection control issue. The facility did not provide any other information about the issue.</p> <p>The facilities Guidelines & Procedure for Hand</p> | F 441 | <p>Resident's primary physician or facility medical director will be contacted for follow up culture and sensitivity after antibiotic therapy. Scissors will be cleaned and disinfected between uses.</p> <p>Licensed nurses will practice infection control protocol while checking blood glucose, administering medications, and assisting with personal care.</p> <p>Nursing staff In-service review of procedure and competency verification hand hygiene/washing, competency verification for blood glucose check, glove use, clean/sanitize scissors, medication cart cleaning and medication administration procedures on 4/9/15.</p> <p>Nursing staff in-serviced on above changes to processes on 4/30/15</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance.</p> | | |

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| F 441 | <p>Continued From page 109</p> <p>Hygiene and Handwashing, dated June 2012, documented: "Wash hands with plain soap and water or with anti-microbial soap and water: *If hands are visibly soiled (dirty); *If hands are visibly contaminated with blood or body fluids; *Before eating; and, *After using the restroom. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: *Before having direct contact with residents; *After having direct contact with a resident's skin; *After having contact with body fluids, wounds or broken skin; *After touching equipment or furniture near the resident; and, *After removing gloves. Note: Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above."</p> <p>2. Resident #7 was admitted to the facility on 7/3/12 with diagnoses which included unspecified schizophrenia, anxiety and other symptoms involving respiratory system.</p> <p>On 3/23/15 at 4:25 PM, CNA #11 was observed as she transferred Resident #7, using the Sit-to-Stand (mechanical device) lift, into the restroom and onto the toilet. The CNA used cleansing wipes, removed her gloves, helped the resident pull up her adult brief, and then transferred the resident off the toilet, using the Sit-to-Stand lift, and back into her wheelchair. The CNA was observed to leave the resident's room without washing her hands. She returned the Sit-to-Stand to the hall storage area and</p> | F 441 | <p>Administrator or designee will audit weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 |

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| F 441 | <p>Continued From page 110</p> <p>entered the room occupied by Resident #15 and #19.</p> <p>On 3/23/15 at 4:35 PM, CNA #11 stated, "I should have washed my hands or used hand sanitizer, but I didn't. I'll put some hand sanitizer on right now."</p> <p>On 3/27/15 at 11:20 AM, the Lead CNA was made aware of the handwashing concern with CNA #11 on 3/23 and stated, "She should have washed her hands."</p> <p>3. On 3/27/15 at 9:15 AM, the DON was interviewed for the Infection Control Protocol.</p> <p>a. The facility's Multidrug-Resistant Organisms (MRSA, VRE, CRE and ESBL) Policy and Procedure, dated April 2013, documented: "Cultures are appropriate for clinical reasons such as determining if infection is present or to guide antimicrobial treatment. Cultures to determine if a resident remains colonized are not generally recommended."</p> <p>When asked how isolation procedures were discontinued, the DON stated, "We need cultures after antibiotic treatment, but some doctors won't give us orders to reculture for MRSA, like in the nares, so we take residents off isolation without cultures." When asked if the facility's Medical Director was contacted for orders, the DON stated, "No."</p> <p>b. When asked how staff were apprised of Infection Control changes in policies and procedures, the DON stated changes were sent to staff in a memo. Additionally, Infection Control Policies and Procedures were addressed in the</p> | F 441 | | | |

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| F 441 | <p>Continued From page 111</p> <p>annual training. When asked how the facility verified staff were aware of Infection Control changes to their policy and procedure, the DON did not respond. When asked if the facility had a signature sheet which verified staff had read and understood the policy changes, the DON stated it did not have documentation that staff knew of changes to policies and procedure.</p> <p>c. Review of the facility's current Infection Control Policy and Procedures revealed the policy and procedures did not include procedures for cleaning and disinfecting scissors which were shared among residents. The DON stated, "I've never seen one."</p> <p>On 3/27/15 at 5:30 PM, the Administrator and DON were informed of the concerns with infection control. No further information was provided.</p> <p>4. On 3/24/15 LN #2 was observed not to establish and maintain infection control while checking blood glucose during medication pass:</p> <p>a. At 11:20 a.m., LN #2 failed to perform hand hygiene before entering Resident #5's room after administering medication to Resident #12.</p> <p>b. At 11:30 a.m., LN #2 was observed gathering equipment for checking blood glucose for Resident #13, including a shared glucometer. She sat the glucometer on a visibly soiled mouse pad, applied gloves, and took blood glucose equipment (including glucometer) into Resident #13's room. She set the glucometer on the bedside table (no barrier used), carried it into bathroom after helping the resident transfer to the toilet, and set the glucometer on the sink (no barrier used). LN then placed the glucometer in her pocket after taking the resident's blood</p> | F 441 | | | |

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| F 441 | <p>Continued From page 112</p> <p>glucose, helped the resident back to bed, then returned to the medication cart and placed the glucometer back on the mouse pad.</p> <p>c. During the observation described in "b" above, LN #2 put gloves on at the medication cart (no hand hygiene preceded this) and entered Resident #13's room to check blood glucose. She helped the resident to the bathroom, checked his blood glucose, and helped him back to bed. Gloves were not observed to be changed throughout this process. LN #2 took the gloves off at the nurse's station, after exiting Resident #13's room, and performed hand hygiene.</p> <p>d. During the observation described in "b" and "c" above, LN #2 was observed checking Resident #13's blood glucose while the resident was using the toilet.</p> <p>5. On 3/25/15, LN #14 was observed not to establish and maintain infection control during medication pass:</p> <p>a. At 7:15 a.m., LN #14 was observed not to perform hand hygiene after administering medications for Resident #20 until she got back to the medication cart.</p> <p>b. At 7:30 a.m., LN #14 was observed not to perform hand hygiene after initiating IV antibiotics for Resident #18 until she got back to the medication cart, also remaining gloved until she returned to the medication cart.</p> <p>c. At 7:55 a.m., LN #14 Joanne was asked how she prepared the medication cart, in regards to infection control. She stated she "wiped down the medication cart after her medication pass." When asked if she knew whether it had been wiped down that day, she said it had not because she had not yet finished her medication pass.</p> <p>6. On 3/26/15 at 9:30 a.m., LN #3 was observed</p> | F 441 | | | |

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| F 441 | Continued From page 113 not to perform hand hygiene before administering Resident #15's eye drops. | F 441 | | | |
| F 456 SS=E | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure 1 of 1 freezer was free from ice accumulation. This had the potential to affect 10 of 10 sampled residents (#s 1-10) and any resident who ate their meals in the facility. This created the potential for food quality to be affected due to an improperly working freezer. Findings included: On 3/23/15 at 1:07 PM, the freezer was observed with frozen water drops on the back half of the ceiling and along the electrical conduit connected to the ceiling which held lights at each end of the freezer. On 3/27/15 at 1:20 PM, the DDS stated, "There should not be ice accumulation on the ceiling, I will have that cleaned off." On 3/26/15 at 6:10 PM, the Administrator and DON were made aware of the concerns in the kitchen. No further information was provided by the facility. | F 456 | 1. Ice accumulation was removed from walk in freezer on 3/28/15. Dietary staff in-serviced by dietary manager on 3/28/15. Walk-in freezer curtain to be installed on 5/11/15. 2. All residents have the potential to be affected by this practice. 3. Dietary staff will report to maintenance if ice accumulation is observed. Walk-in freezer inspection for de-icing and inspection of freezer curtain placed on TELS program weekly. Dietary staff in-served 4/25/15 and Maintenance staff in-served 4/24/15 to changes in process. 4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Administrator or designee will audit changes to process weekly X 4, monthly X 2, and quarterly X 3. | | |
| F 497 SS=E | 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE | F 497 | | | |

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| F 497 | <p>Continued From page 114</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</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 certified nurse aides (CNAs) received at least 12 hours of competency training and performance review in the last year. This was true for 13 of 26 CNAs employed in the facility. This failed practice could result in harm if residents did not receive appropriate care for their individual care needs. Findings included:</p> <p>On 3/27/15 at 10:40 AM, the Staff Development Coordinator (SDC) was interviewed, with the Lead CNA present, regarding CNA training. The SDC said new CNA staff had been trained, but the yearly skills training and competency reviews for the remainder of the CNA staff was not completed in 2014 and had not been completed yet for 2015. She said there was a training scheduled in 2014, but it was canceled due to staff changes and had not yet been rescheduled.</p> | F 497 | <p>5. Compliance on or before May 30, 2015.</p> <ol style="list-style-type: none"> 1. Annual skills training completed 4/9/15. Performance review of nurse aides completed on or before 5/30/15. 2. All residents have the potential to be affected by this practice. 3. Training for resident individualized care needs will be provided in monthly nursing staff in-services. Nurse aide skills training and competency reviews will be completed and documented annually. Staff development coordinator was in-serviced on change to this process on 4/29/15. 4. Monitoring: results of audits will be taken to QAA committee for | 5/30/15 | |

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| F 497 | Continued From page 115 On 3/27/15, a list of all CNAs who worked in the facility was requested and received. Of the 26 CNAs on the list, 13 had been hired prior to 2014. | F 497 | root cause analysis for further monitoring and modification to sustain compliance. DNS or designee will audit weekly X 4, monthly X 2, and quarterly X 3. | |
| F 514 SS=D | On 3/27/15 at 5:30 PM, the Administrator, DON and Social Worker were informed of the issues. No further information was provided by the facility. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain accurate and complete clinical records for 3 of 11 residents (#1, #2, & #7). This failure created the potential for medical decisions to be based on inaccurate information. Findings included: 1. Resident #2 was admitted to the facility on 2/10/14 with multiple diagnoses, including Diabetes Mellitus (DM). On 8/4/14 the resident | F 514 | 5. Compliance on or before May 30, 2015. 1. Resident #2 Case manager contacted wound clinic to request wound culture results to confirm accurate antibiotic treatment. Wound clinic lab results obtained and included in resident's record. Resident #1 Order for Glucagon clarified to refer to Hypoglycemic Incidents Procedure. Resident #7 Care plan for AVAP updated to match order on 3/26/15. 2. All residents have the potential to be affected by this practice. 3. Facility will collaborate with wound clinic to ensure complete medical record is obtained on admission in order to make | 5/30/15 |

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| F 514 | <p>Continued From page 116</p> <p>was re-admitted with a right heel wound, with treatment from a local wound clinic.</p> <p>On 3/5/15, the wound clinic ordered antibiotics for Resident #2, "Levofloxacin 750 mg (milligrams) by mouth one time daily for 10 days for pressure ulcer" according to Recapitulation orders. No infection was identified at the time of this order.</p> <p>On 3/26/15 at 10:45 a.m., the DON stated she did not know why the resident was started on the antibiotic, but "if the clinic prescribed it, it's for that heel, but I don't know the bug." The DON agreed this information would be important to know, and she would look for it.</p> <p>On 3/27/15 at 4:55 p.m., LN #8 stated she did not know what type of infection was in the resident's heel, but would get this information from the wound clinic.</p> <p>On 3/27/15 at 5:30 p.m., the Administrator, DON, Director of Social Services, and Case Manager were informed of the issue.</p> <p>On 3/30/15 at 9:30 a.m., facility faxed information to Bureau of Facility Standards from wound clinic with lab results obtained prior to the start of Levofloxacin. However, those results had not been included in the resident's record at the facility.</p> <p>2. Resident #1 was admitted to the facility on 11/22/11 with diagnoses which included diabetes mellitus II, anxiety, depression and dementia.</p> <p>Review of the resident's Medication Review Report (MRR) for March 2015, documented a 9/30/13 order for, "Glucagon Emergency Kit 1 MG (Glucagon (rDNA)) Inject 1 gram intramuscularly</p> | F 514 | <p>medical decisions based on accurate information.</p> <p>Licensed nursing will now follow Hypoglycemic Incidents Procedure. Licensed nurse will reconcile order and care plan for accurate information regarding AVAP oxygen liter flow and care plans.</p> <p>Licensed social worker, Health information manager, Case managers, and licensed nurses re-educated on the changes to these processes 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Health information manager or designee will audit medical records for accuracy and completeness weekly X 4, monthly X 2, and quarterly X 3.</p> <p>5. Compliance on or before May 30, 2015.</p> | | |

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| F 514 | <p>Continued From page 117 as needed for Blood Glucose < 80...Give if unable to swallow glucose gel" for the diagnosis of diabetes.</p> <p>The resident's Medication Record (recapitulation orders) for March 2015, documented the 9/30/13 order, "Glucagon Emergency Kit 1 MG (Glucagon (rDNA)) Inject 1 gram intramuscularly as needed for Blood Glucose < 80." Note: The order was unclear as it documented the Glucagon Emergency Kit 1 MG and to inject 1 gram. The conversion factor for grams to milligrams: 1 gram equals 1000 milligrams.</p> <p>On 3/26/15 at 2:20 PM, the DON stated, "The order was typed in wrong, I'd have to look it up, someone physically typed in it wrong."</p> <p>3. Resident #7 was admitted to the facility on 7/3/12 with diagnoses which included unspecified schizophrenia, anxiety and other symptoms involving respiratory system.</p> <p>The Medication Review Report for March 2015, documented an 8/8/14 order for AVAP with 02 (oxygen) at 3 LPM (liters per minute) one time a day for sleep disorder related to insomnia. Note: AVAP (Average Volume Assured Pressure) is a device which delivers consistent tidal volume for those who require ventilatory support.</p> <p>Resident #7's care plan for altered respiratory status/difficulty breathing related to sleep apnea, initiated on 5/8/14, documented an intervention to "Report to Nurse any difficulties [name of resident] has with use of AVAP." An intervention was added on 8/8/14 for, "Oxygen therapy via AVAP HS [hour of sleep] 2 LPM."</p> | F 514 | | 5/30/15 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 514 | Continued From page 118 On 3/26/16 at 4:35 PM, LN #4 stated, "the order for 3 LPM is correct." | F 514 | | | |
| F 520 SS=E | On 3/27/15 at 5:30 PM, the Administrator and DON were informed of the concerns regarding inaccurate documentation. No further information was provided by the facility. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: | F 520 | 1. QAA Committee met Wednesday, April 22, 2015 to address current diabetic management, behavior monitoring and other survey issues identified. Medical director and Consultant Pharmacist were present. All survey tags were discussed and plan of correction started for the process of improvement. 2. All Residents have the potential to be affected by this practice. 3. Diabetic management and behavior monitoring results will be brought to QAA meetings for further monitoring and modification. QAA committee will develop and implement appropriate plans of | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/30/2015 |
|--|--|--|--|--|
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| F 520 | <p>Continued From page 119</p> <p>Based on record review and staff interview, it was determined the facility failed to implement the Quality Assessment and Assurance (QAA) process when diabetic management and behavior monitors were not addressed. This created the potential to harm residents if diabetic care was inappropriate or psychotropic medications were administered without adequate monitors. Findings included:</p> <p>Federal guidance for F520 documented the QAA committee was responsible for identifying quality deficiencies and developing and implementing plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans.</p> <p>1. On 3/26/15 at 3:55 PM, the facility was cited at F309 for an Immediate Jeopardy, when it failed to identify and consistently follow appropriate acceptable standards of care for residents with diabetes. This included the failure to follow hypoglycemic policy, failure to develop a hyperglycemic policy, and failure to ensure residents orders were appropriate for diabetic management. Refer to F309 for additional information.</p> <p>On 3/27/15 at 3:00 PM, the Administrator was interviewed regarding diabetic management practices in the facility. When asked if the QAA committee had been aware or had identified diabetic management issues in the facility, he stated, "I don't believe so."</p> <p>2. The facility was cited at F329 on 12/20/13, during the last recertification survey, and on 3/30/15, when it failed to implement appropriate</p> | F 520 | <p>action to identify and correct quality deficiencies; including monitoring the effect of implemented changes and making needed revisions to the action plans.</p> <p>Licensed nursing staff and Social service director re-educated on Quality Assurance and Performance Improvement to address diabetic management and behavior monitoring on 4/30/15.</p> <p>4. Monitoring: results of audits will be taken to QAA committee for root cause analysis for further monitoring and modification to sustain compliance. Administrator will audit committee minutes for diabetic management and behavior monitoring monthly x 12.</p> <p>5. Compliance on or before May 30, 2015.</p> | 5/30/15 |

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

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| F 520 | Continued From page 120 behavior monitors for resident on psychotropic medications. Refer to F329 for additional information. On 3/27/15 at 3:00 PM, the Administrator was interviewed regarding behavior monitors. He said behavior monitor issues were brought up in monthly behavior meetings. When asked if these issues were brought to the QAA meeting and discussed there, he stated, "I don't believe it's been discussed in QA." | F 520 | | | |